CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionaire. This confidential history will be part of your permanent records.

Name:_____ Birthday:_____ Sex: M F

Address:_____ City/St: _____ Zip:_____

Soc. Sec. # _____Home Phone: ( )_____ Cell Phone: ( )_____

Marital Status: M S D W Children, Ages:_____ Spouse's Name:_____

Occupation: _____Employer:_____ Work Phone: ( )_____

Email Address*:_____ Who referred you to us? _____

What is your chief complaint?_____

_____

How long have you had this condition?_____

Have you had this or similar conditions in the past?_____

Do any positions make it feel worse?_____ Better? _____

Is this condition: (circle one) Improved Unchanged Getting worse

Is this condition interfering with: (circle as many indicated) Work Sleep Daily Routine Social Habits

List doctors or therapists who have treated THIS condition:_____

What do you think caused this condition?_____

List surgical operations and years: _____

_____

Allergies:_____

Were you referred here by a healthcare provider? Yes No If so, who?_____

Do you have a family physician? Yes No

Name:_____

Address:_____ Office Phone #:_____

Medications, dosages and frequency: _____

_____

Have you been in an auto accident, work injury, or other personal injury? Yes No

If yes, please describe: _____

_____

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Patient Name: Date of birth:

FAMILY HISTORY

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sisiter(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY

Current Weight: _____ Have you recently lost or gained weight? _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Smoking ☐ Current ☐ Previous Packs per day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of years _____

Caffeine (Cola, Tea, Coffee) Cups/Day _____ No. of years _____

Water Intake Cups/Day _____ No. of years _____

Pain Relievers (NSAIDS) No./Day _____ No. of years _____ Others _____

Vitamins No./Day _____ No. of years _____ List Vitamins _____

Hobbies _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Belden Village Chiropractic and Associates all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I authorize my x-rays to be released to a Radiologist and I agree to pay for the cost of the Radiologist's report.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. I understand that any unpaid balances will be subject to an 18% APR interest charge if the balance exceeds 60 days unpaid. I understand that if I do not pay my bill I will be sent to a collection agency and my credit may be affected. I agree to pay any collection cost that may occur if I do not pay my bill within 60 days of being notified that a balance is due. I acknowledge that it is not the clinics job to track my balance and I am soley responsible to make sure my account is paid in full and on time.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____

Signature of Patient /Insured / Guardian Date Signed

Belden Village Chiropractic and Associates
4200 Munson St., Suite B
Canton, OH 44718
(330) 493-0009

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Belden Village Chiropractic and Associates, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury that someone else might be responsible for? ____ Yes ____ No

To the best of your knowledge are you pregnant? ____ Yes ____ No

I give my permission to the doctors to take x-rays for diagnostic interpretation ____ Yes ____ No

Missed Appointments:

There will be a $40 fee charged for all missed appointments if not cancelled within 24 hours of the visit. _____ (Initial here)

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, or in case of an emergency, whom may we contact?

Spouse: _____ Phone: _____

Children: _____ Phone: _____

Others: _____ Phone: _____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

I, _____, have read and fully understand the above statements.

Acknowledgement

I have received the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____ Date of birth: _____

Signature: _____ Date: _____

Belden Village Chiropractic and Wellness Center **330-493-0009**
4200 Munson St., Suite B, Canton, Ohio 44718

INSURANCE INFORMATION

Patient Name: _____ DOB: _____

Primary Insurance:_____

ID#_____ Group#:_____

Name of Insured:_____

Insured's Date of Birth:_____

Employer: _____

****Do you have a Secondary Insurance? (Mark one) Yes_____ No_____

Secondary Insurance:_____

ID#:_____ Group#:_____

Name of Insured:_____

Insured's Date of Birth:_____

Employer: _____

****Are your present symptoms or conditions related to or the result of an auto collision, work-related injury, or other personal injury that someone else might be responsible for? (Mark One) Yes _____ No _____**

Patient Signature _____ Date _____