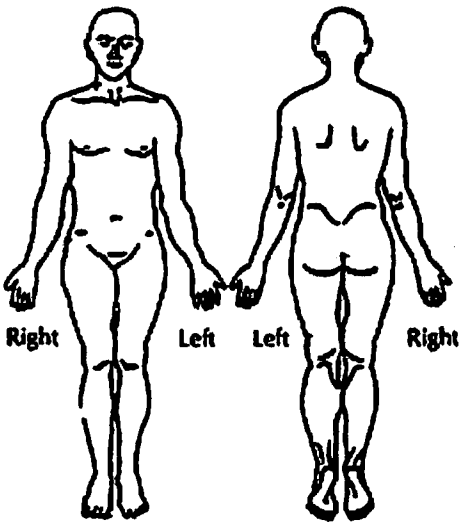
DAYTON CHIROPRACTIC AND REHAB

8940 Kingsridge Dr., Suite 101
Dayton, OH 45458

If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area on the diagram below and label accordingly.

A= Ache B= Burning S=Stabbing N=Numbness P=Pins & Needles



Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

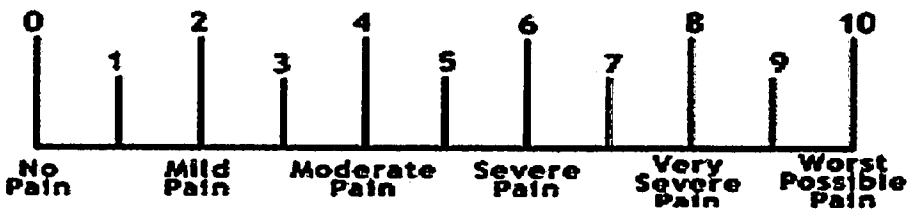
Surgeries: _____

_____

Medications: _____

_____

Pain Scale: Please circle the number below that best describes your current pain.



Patient's Signature_____ Date___/___/___

Print Name_____

Dayton Chiropractic & Rehabilitation Center, Inc.
8940 Kingsridge Dr. Ste 101
Dayton OH 45458

File # : _____

Date: _____

Name: _____ Home Phone: ( ) - _____ Work Phone: ( ) - _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ Age: _____ M: _____ F: _____

Marital Status: Single: ___ Married: ___ Widowed: ___ Divorced: ___ Student: Full-Time: ___ Part-Time: ___

Employer's Name: _____ Occupation: _____ Years: ___

Employer's Address: _____ City: _____ State: _____ Zip: _____

Do you have health and accident insurance? Yes ___ No ___

If "yes", with what company? _____ Policy # : _____

Are you a member of an HMO? Yes ___ No ___ Additional insurance self / spouse, Policy # : _____

If retired, state company name that you retired from which your group health insurance is with: _____

Spouse's Name: _____ Date of Birth: ____ / ____ / ____ SS#: _____ - _____ - _____

Spouse's Employer Name & Address: _____

_____ Work Phone: ( ) - _____ Occupation:

Are you covered under spouse's / parent's insurance? Yes ___ No ___

How did you find out about us? ☐ Newspaper ☐ Flyer ☐ Yellow Pages ☐ Radio ☐ Friend ☐ TV ☐ OTHER

Person to call in an emergency: _____ Phone: ( ) - _____ Relationship:

Have you ever been a patient here before? Yes ___ No ___ When?: _____ For what problems? _____

PRESENT COMPLAINT IS DUE TO: CHECK ALL THAT APPLY

☐ On the job injury (use form)	☐ Auto accident (use form)	☐ Illness
☐ Home Injury (use form)	☐ Accident not at home	☐ Disease
☐ Athletic injury	☐ Someone's else's negligence	☐ Old Injury
☐ School supervised sport	☐ Poor Physical Conditioon	☐ Other (explain) _____

CURRENT PROBLEM

What is the health problem you want to talk to the doctor about? _____

Date first noticed pain: _____ How long have you had this condition? _____

When was the last time? _____ What activities aggravate your condition? _____

Is the condition getting worse? Yes ___ No ___ Comes & Goes ___

Number of episodes per day _____ week _____ month _____

Condition interfering with your: Work ___ Sleep ___ Daily Routine ___ Other ___ = _____

I CERTIFY THAT ALL INFORMATION IS TRUE AND CORRECT. I hereby authorize the release of any information requested by this office. I also authorize my benefit payments to be made directly to this clinic. If my current policy prohibits direct payments to doctors, then I hereby also instruct and direct my insurance company to make out the check to me and mail it to this office. I understand that I am financially responsible for all services rendered. I agree that if my treatment here is suspended or terminated, the bill will become immediately due and payable. All x-rays are the property of Dayton Chiropractic and Rehabilitation Ctr, Inc.; I authorize Dayton Chiropractic & Rehabilitation Ctr, Inc. to file a written formal complaint to the insurance commissioner, or Department of Labor on my behalf.

_____ _____

Signature of Patient / Guardian Date

Dayton Chiropractic and Rehabilitation Center
8940 Kingsridge Dr. #101
Dayton Oh 45458

Consent to Treat

I, _____ consent for myself or for _____, a minor child, Dayton Chiropractic and Rehabilitation Center and its representatives to perform upon myself the following procedures: Exam, x-rays, ancillary therapies, and adjustments as deemed necessary by the doctor. Massage, exercise and stretching may also be included. All risks associated with the above, will be explained to me by the associate doctor before they are preformed. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure(s).

_____ _____
Patient Signature or Guardian Date

I also declare to the best of my knowledge that I am not pregnant. (Please let the receptionist know if you believe you are pregnant.)

_____ _____
Patient Signature or Guardian Date

HIPPA Consent

We may disclose your personal and health related information about you in the following ways: To another healthcare provider, hospital, or facility for further diagnosis, assessment or treatment. to an Insurance carrier, HMO, or employer if they may be responsible for payment of services, or used for patient success stories, referral boards, or other educational information. If you are not at home to receive an appointment reminder, a message may be left on your answering machine or with a person in your household.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. If you have a complaint regarding our privacy notice, our privacy practices, any of our privacy activities, or if you would like further information about our privacy policies and practices please contact Dr. Brian Johnson.

It is our desire of this office to provide chiropractic care in an "open door" adjusting/therapy environment. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. It is your right to deny use of "open door" adjusting/treatment and will not be disadvantages by this office or our staff in any manner whatsoever.

My signature acknowledges that I have read, understand and comply with this notice.

_____ _____
Signature Date

PATIENT MEDICAL HISTORY QUESTIONAIRE

(Please print.)

Name: _____ Today's Date: ____/____/____

Birth Date: ____/____/____ Last Eye Exam: ____/____/____ Last Medical Exam: ____/____/____

Name of Family Doctor:_____ Dr.'s Phone: _____

MEDICAL HISTORY:

Do you have **ANY ALLERGIES** (medications, seasonal etc) ? Yes No If yes please list:_____

List **ANY MEDICATIONS** you take (birth control, vitamins and any over the counter medications & home remedies.)

List all **major** illnesses, that you have (diabetes, high blood pressure, **glaucoma** etc) or injuries (i.e. concussions)

FAMILY HISTORY: (Please note any family history, parents, grandparents, siblings, children, living or deceased)

Disease	Yes	No	Unsure	Relation	Disease	Yes	No	Unsure	Relation
Blindness					Cancer				
Cataract					Heart Disease				
Crossed Eyes					High Blood Pressure				
Glaucoma					Kidney Disease				
Macular Degeneration					Other:				

SOCIAL HISTORY: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* ☐ Yes, I would like to discuss my Social History information directly with my doctor. (check box)

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? No Yes

Do you use tobacco products? ☐ No ☐ Yes Do you drink alcohol? ☐ No ☐ Yes Do you use illegal drugs? ☐ No ☐ Yes

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphillis ☐ None

REVIEW OF SYSTEMS: Do you **currently** have any problems in the following areas:

System	Yes	No	System	Yes	No	System	Yes	No
Eyes			**Constitutional**			**Vascular / Cardiovascular**		
Loss of Vision			Weight Loss / Gain			High Blood Pressure		
Blur			Fever			Stroke		
Halos			**Integumentary (Skin)**			Heart Problems		
Double Vision			**Neurological (Headaches)**			**Genitourinary**		
Dryness			**Endocrine**			Kidney Disease		
Mucous Discharge			Thyroid			**Bones / Joints / Muscles**		
Redness			Diabetes			Arthritis		
Gritty / Sandy Feeling			**Ears, Nose, Throat, Mouth**			**Lymphatic / Hematologic**		
Itch			Sinus			Anemia		
Burn			**Respiratory**			**Allergic / Immunologic**		
Tearing			Asthma			Seasonal		
Pain			COPD			Medicine		
Flashes of Light			Bronchitis			**Psychiatric**		
Floaters			Emphysema			Depression		
Gastrointestinal						Anxiety		
Diarrhea / Constipation								

Other Health Problems not listed: _____

_____ _____ _____ _____

Patient / Guardian Signature Date Doctors Initials Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name or Insured: _____

Insurance Company: _____

Claim Number: _____

Date of Accident: _____

I hereby instruct and direct _____ Insurance Company to pay **Dayton Chiropractic & Rehabilitation Center, Inc** directly by check and is to be sent directly to:

Dayton Chiropractic & Rehabilitation Ctr
8940 Kingsridge Dr. Ste 101
Dayton OH 45458

If my current policy prohibits direct payments to doctors, then I hereby also instruct you to make out the check to me and mail it as follows:

C/O Dayton Chiropractic & Rehabilitation Ctr
8940 Kingsridge Dr. Ste 101
Dayton OH 45458

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtness to the above-mentioned assignee.

A photocopy of this Agreement shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder

Dated this _____ day of _____ 20___.

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HEALTH INSURANCE FINANCIAL AGREEMENT

Most insurance policies cover chiropractic care. This office makes no representation that yours does. Policies differ greatly in terms of deductible and percentages of coverage for chiropractic.

Upon verification of your insurance coverage, your policy requires that you pay $_____ deductible and _____% or $ _____ co-payment of your charges. State law, as of April 9, 1994 requires that we attempt to collect this amount.

Your treatment costs are $_____per visit with a co-payment of $_____per visit. You will be requested to pay $_____ per week toward your balance. We expect that every effort will be made to pay your balance. Should this create a financial burden for you, you may request a financial hardship statement.

It is our policy to have our "Assignment of Benefits" form signed by you. This form instructs your insurance company to make payments directly to this office. Please sign all copies of this form. Some insurance companies do not honor assignment of benefits and payment may come to you. We require that you forward us the payment along with the explanation of benefits within five days of your receipt of it.

Some insurance companies require that a claim form be filled out and mailed in before payment is made. If you have such an insurance company policy, it will be your responsibility to furnish one to this office. You should be able to obtain one fro either your employer or your insurance company, By signing this agreement, you are agreeing to allow us to release medical information, such as initial reports, progress reports and any other information required. Your signature authorizes the release of medical information necessary to process your claim.

If you suspend or terminate your care at any time without the release of the doctor, your portion of all charges for professional services will become immediately due and payable.

We would like to welcome you to our office and thank you for choosing us. IF you have any questions at any time, please do not hesitate to ask.

I have read, understand and agree to the above.

_____ _____
PATIENT/GUARDIAN'S SIGNATURE DATE