Baker Chiropractic
ORTHOSPINOLOGY CLINIC

(Please print)

NAME:_____DATE:___/____/____SS#_____

DOB:_____ Age:_____ Circle one: Male Female Number of children : _____

Address:_____City:_____State:_____Zip:_____

Cell Phone:_____Home Phone:_____Work phone:_____

Email:_____ Can we text appointment reminders? _____
Can we email appointment reminders? _____
Your employer : _____ Occupation: _____

Circle one: Married Divorced Widowed Single Separated Minor
Emergency contact: _____ Phone number: _____

Name of person responsible for this account _____
Relationship to patient_____

What type of exercise do you perform on a daily basis? (Circle one) none moderate heavy

What vitamins do you currently take?: _____

What kind of nutritional supplements do you take (if any)?_____

Do you smoke? (Circle one) yes no How much per day? _____

How much alcohol do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____
Reason for visit? _____
Have you had any MRI's, Xrays or other imaging done? _____ Where?_____
When did you first notice symptoms? _____
Is the condition progressively worse? _____
Where is pain located?_____
Is the pain constant or does it come and go? _____
Type of pain: (Circle all that apply) sharp dull throbbing numb aching shooting burning tingling cramps stiff swelling other _____

Rate the severity of your pain: 1 2 3 4 5 6 7 8 9 10 (1, mild to 10 severe)

Have you received any treatment for your condition (example: medication, surgery, physical therapy)?

_____

Have you had previous chiropractic care? _____ If so, date of last exam: _____
Name of other doctor(s) who have treated you for your condition: _____

Health History: Circle only those conditions you have or have had
AIDS/HIV, ALCOHOLISM, ALLERGY SHOTS, ANEMIA, ANOREXIA, APPENDICITIS, ARTHRITIS, BLEEDING DISORDERS, BREAST LUMP, BRONCHITIS, BULIMIA, CANCER, CATARACTS, CHEMICAL DEPENDENCY, CHICKEN POX, DEPRESSION, DIABETES, EMPHYSEMA, EPILEPSY, FRACTURES, GLAUCOMA, GOITER, GONORRHEA, GOUT, HEART DISEASE, HEPATITIS, HERNIA, HERNIATED DISC, HIGH BLOOD PRESSURE, HIGH CHOLESTROL, KIDNEY DISEASE, LIVER DISEASE, MEASLES, MIGRAINES, MISCARRIAGE, MONONUCLEOSIS, MULTIPLE SCLEROSIS, MUMPS, OSTEOPOROSIS, PACEMAKER, PARKINSON'S DISEASE, PINCHED NERVE, PNEUMONIA, POLIO, PROSTATE PROBLEMS, PROSTHESIS, PSYCHIATRIC CARE, RHEUMATOID ARTHRITIS, RHEUMATIC FEVER, SCARLET FEVER, STROKE
OTHER _____

List any type of surgeries you have had and the dates you had them:

_____

_____

(Women) Are you pregnant? _____

List all medications you are currently taking:_____
_____
_____

Allergies: _____

Who may we thank for referring you? _____

This office accepts, cash, checks, credit cards (No American Express). To keep our fees reasonable, payment is expected at the time of service. We do not accept insurance. We will file out of courtesy and they will mail the patient a check for whatever they reimburse for out of network chiropractors. I understand my insurance may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby authorize authorize the release of any information regarding my treatment to my insurance company or myself.
I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered.

X_____ X_____ X_____
Signature Date Parent (If patient is a minor)

PATIENT INFORMATION SHEET

NAME_____ DATE: _____

ALLERGIES - PLEASE CIRCLE ALL THAT APPLY

ANIMALS, ASPIRIN/PAIN MEDICINE, BEE STINGS, CHOCOLATES/SWEETS, DAIRY (MILK, CHEESE), DUST, EGGS, LATEX, MOLD, PENICILLIN, RAGWEED/POLLEN, RUBBER, SHELLFISH, SEASONAL ALLERGIES, SOAPS, WHEAT, XRAY DYE,
OTHER_____

ALLERGIES TO ANY MEDICATIONS – PLEASE LIST

_____
_____
_____

SURGERIES – PLEASE CIRCLE

APPENDIX, BACK, CARPAL TUNNEL, TUMORS, BRAIN, CHEST, DISC, EENT, ELBOW, FOOT, GALLBLADDER, GASTRO, GYNECOLOGIC, HEART, LUMBAR, HERNIA, HIP, KNEE, NECK, NEUROLOGICAL, OBSTETRICAL, PODIATRIC, SHOULDER, THORACIC, WRIST/HAND
OTHER_____

MEDICAL HISTORY – PLEASE CIRCLE FOR YOURSELF. BLOOD RELATIVE PT "BR" BESIDE IT

ANKLE PAIN, ARM PAIN, ARTHRITIS, ASTHMA, BACK PAIN, BROKEN BONES, CANCER, CHEST PAIN, DEPRESSION, DIABETES, DIZZINESS, ELBOW PAIN, EPILEPSY, FAINTING, VISION PROBLEMS, FATIGUE, FOOT PAIN, GENETIC SPINAL DISORDER, HAND PAIN, HEADACHES, HEARING PROBLEMS, HIGH BLOOD PRESSURE, HEPATITIS, HIP PAIN, JAW PAIN, JOINT STIFFNESS, KNEE PAIN, LEG PAIN, LOW BACK PAIN, MENSTRUAL PROBLEMS, NEUROLOGICAL DISORDER, NECK PAIN, PACEMAKER, PARKINSON'S, POLIO, PROSTATE PROBLEMS, SHOULDER PAIN, SIGNIFICANT WEIGHT CHANGE, SPINAL CORD INJURY, SPRAIN/STRAIN, STROKE, HEART ATTACK, STOMACH PROBLEMS, TUMOR, ULCER, WRIST PAIN

PREFERRED LANGUAGE: _____
DO YOU SMOKE?: _____
RACE: _____

X_____ DATE _____

DOCTOR – PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialties of chiropractic osteopathy and medicine. Chiropractic healthcare seeks to improve health through natural means without the use of drugs or surgery. This helps the body maximize its inherent healing ability. The success of the doctor of chiropractic procedure often depends on underlying causes, as well as other spinal and physical conditions. It is important to understand what to expect from your chiropractic healthcare.

ADJUSTMENTS

Dr Mark Baker utilizes the Orthospinology procedure, which is a low force, non-rotary upper cervical technique. If adjustments to the lower spine are required, then the doctor will usually utilize a low force non-rotary, drop table, hand-held instrument or flexion-distraction adjustment technique. Other various forms of physical therapy may be necessary in your case.

INFORM CONSENT FOR CHIROPRACTIC CARE

As a patient, you give the doctor permission and authority to care for you in accordance with the chiropractic tests and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects or pathologies may render a patient susceptible to injury. The doctor will not provide healthcare, if he is aware that such care may be contraindicated. Again, it is your responsibility to tell the doctor everything you know about your health conditions, which would otherwise not come to the attention of the doctor. The doctor of chiropractic provides a specialized, non-duplicating health service, but he is also available to work with other types of healthcare providers.

RESULTS

As a patient in this office, you are acknowledging that your doctor or his assistants have given no guarantee as to the results that may be obtained from your care. The doctor also wants it understood that although he does not utilize rotary manipulation, he is in no way indicating that his procedures are superior to his fellow chiropractors. Please understand that chiropractic care is not a treatment of a disease, but a system of correcting vertebral subluxations.

AUTHORIZATION

In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and/or insurance representatives for gaining a second opinion or reimbursement from insurance carriers. As a patient, you are giving the doctor permission to use his best judgement for when to allow and observer in the room or when it's necessary to release the above patient information. I also give permission for the doctor to use information from my examination to help evaluate statistics for research, as long as my name is not used.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy, I have had the above explained to me and after reading it, I understand the foregoing and give my consent

Signature _____ Date_____

BAKER CHIROPRACTIC FINANCIAL AGREEMENT

The purpose of this agreement is to clarify the financial aspects of your care and to avoid and misunderstanding concerning payment for professional services. This way we can devote our efforts to helping you get the best results in the shortest amount of time. PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. PATIENT IS RESPONSIBLE FOR ALL CHARGES. Prompt payment allows us to control costs. Outstanding accounts cost time and money.

Insurance

We are not in network with any insurance companies. Payment is due at time of service. We will file your insurance claims as a courtesy. Any benefits payable from your insurance company will be mailed to your directly from the insurance company.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. Please contact us immediately if you have any questions or need assistance.

What will it cost for the initial visit?

$400 includes consultation, examination, pre x-rays, reports of findings on x-rays, office visit.

We accept cash, credit cards (NO AMERICAN EXPRESS) and personal checks.

I have read, understood and agreed to this agreement.

X_____ DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Patients name) acknowledgment that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Baker Chiropractic Clinic, which describes the information created, received or maintained by the Practice.

_____ Date

_____ Signature

_____ Print name

_____

_____

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The practice has made a good faith effort to obtain an acknowledgement of _____ (Patients name)'s receipt of our Notice of Privacy Practices. In spite of these efforts, the practice has been unable to obtain a signed acknowledgement of receipt for the following reason (check all that apply):

____ Patient Unavailable
____ Patient Physically Unstable
____ Patient Unwilling

In an effort to obtain the patients acknowledgment, the practice has attempted to provide patient with a Notice of Privacy Practices in the following manner. (check all that apply)

___ Personally ___Mail ___Phone follow up ___Other_____

_____ Date