Kamego Chiropractic ***Welcome!*** *Thank You For Choosing Our Office*

General Information

Name: _____Age: ___ Today's Date: _____
Address: _____City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Social Security Number: _____ Birth Date: _____
Occupation: _____ Employer: _____
E-Mail: _____ Spouse's Employer: _____
Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed
Name of spouse: _____ Number of Children: _____
Person to contact in an emergency: _____ Phone # _____
Name of primary care physician _____ Phone _____
Whom can we thank for referring you to us? _____
If not a referral- how else did you hear about us: _____

Insurance Information

Name of person responsible for this account? _____
Relationship to patient _____ Phone # _____

Type of insurance: □ Health insurance □ Worker's Comp. □ Automobile Insurance □ None

Primary Insurance Company: *We will make a copy of your insurance cards and verify benefits for you*!

General History

Sex: Male □ Female □ Height: _____ft. _____in. Weight _____lbs.
What type of exercise do you perform on a daily basis? □ None □ Light □ Moderate □ Heavy
Do you smoke? □ No □ Yes If yes, how much? _____ pack(s) per day
Is there any chance of you being pregnant? □ Yes □ No
Have you previously been under chiropractic care? □ Yes □ No
List any broken bones and/ or surgeries, cancers:_____
_____
Current Medications and supplements:_____

Check any of the following you may be currently experiencing now or in the past few months:

□ Eye Pain	□ Cancer	□ Colic	□ Dizziness/Vertigo
□ Headaches	□ Diabetes	□ Hay fever	□ Weight loss/gain
□ Neck pain	□ Gas	□ Arthritis	□ Insomnia
□ Upper back pain	□ Colitis	□ Gall bladder	□ Skin problems
□ Lower back pain	□ Constipation	□ Kidney trouble	□ Male Problems
□ Numbness	□ Diarrhea	□ High blood pres.	□ Female problems
□ Shoulder pain	□ Nervousness	□ Low Blood pres.	□ Hypoglycemia
□ Muscle spasms	□ Chest pains	□ Heart Disorders	□ Slurred Speach
□ Arm Pain	□ Rib Pains	□ Blurred Vision	□ H.I.V.
□ Leg Pain	□ Allergies	□ Vision Disorders	□ Respiratory Issues
□ Ankle/Foot pains	□ Excessive Thirst	□ Psychologic Issues	□ Cardiovascular issues
□ Hand/Wrist pains	□ Asthma	□ Ringing in ears	□ Bruises easily
□ TMJ/Jaw Pain	□ Depression	□ Chronic Sinusitis	□ Ear Infections

Current Condition Information

Describe Your Major Complaints: _____
_____

What may have caused your problem? *Check any that apply*: ___Fall, ___Overexertion, ___Repetitive Injury ___Work accident, ___Auto Accident, ___No Injury, ___Unknown, Other:_____

Date this problem started? _____
Have you had similar symptoms or injuries before? □ Yes □ No If Yes, please explain: _____
_____

What other doctors have you seen for this condition: _____
_____

What tests have you had for this problem? Where and when were they performed?
_____
_____

Check any previous treatments: ___None, ___Chiropractic, ___Pain Medications, ___Rest, ___Heat, ___Ice, ___ Muscle Relaxers, ___Physical Therapy, ___Injections, ___Surgery, ___Exercise, Other_____
Results of previous Treatment:_____
_____

How often do you experience your symptoms?

- □ Constantly (76-100% of the day)
- □ Frequently (51-75% of the day)
- □ Occasionally (26-50% of the day)
- □ Intermittently (0-25% of the day)

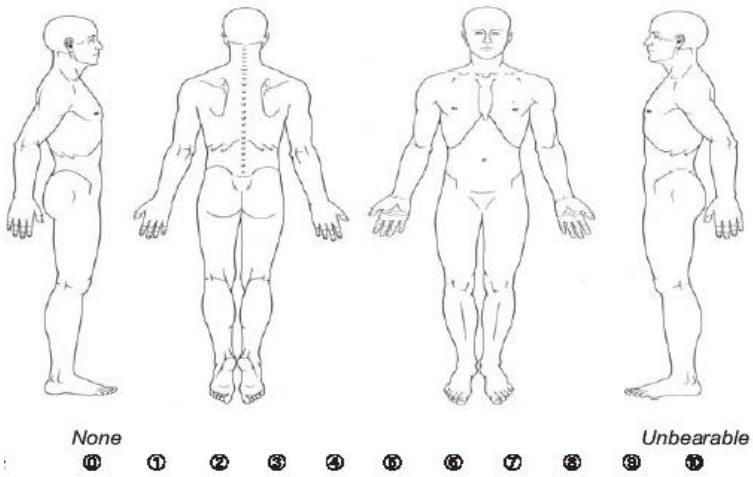
What describes the nature of your symptoms?

- □ Sharp □ Shooting □ Stabbing
- □ Dull □ Burning □ Throbbing
- □ Numb □ Tingling □ Nagging
- □ Other_____

Has this problem been:

- □ Getting better
- □ Getting worse
- □ Staying the same

Indicate where you have pain or other symptoms



Circle Average and Worst Level of Pain Intensity (Above)

Past Falls, Wrecks, and Traumas

1. Year: _____ Description: _____

2. Year: _____ Description: _____

3. Year: _____ Description: _____

Authorization, Assignment, and Release

Waiting for insurance payment is a courtesy provided by our office. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits in order to lessen the initial financial burden for you while waiting for reimbursement. The insurance carriers are billed on a weekly cycle.

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to this clinic. The professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy will be used as a payment toward the total charge for professional services rendered by this clinic.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case; and hereby release this clinic of any consequence thereof.

Acknowledgement and Understanding

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although chiropractic care is one of the safest forms of health care, it is associated with some minor risks, and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

I clearly understand that my records and x-rays are property of Kamego Chiropractic Wellness Center and that in case I need a copy of my records and x-rays, there will be an additional charge for that.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Kamego Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Kamego Chiropractic's Notice of Privacy Practices prior to signing this document. Kamego Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kamego Chiropractic Clinic. The Notice of Privacy Practices for Kamego Chiropractic Clinic is also provided on request at the main administrative desk of this practice and on Kamego Chiropractic's website at **www.kamegochiro.com**. This Notice of Privacy Practices also describes my rights and Kamego Chiropractic's duties with respect to my protected health information.

Kamego Chiropractic Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Kamego Chiropractic website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Financial Responsibility & Consent for Treatment

I understand and agree that (Regardless of insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on all sides of this packet and have completed all questions. I certify this information is true and correct to the best of my knowledge. I will not hold my doctor or any staff member of Kamego Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form. I will notify the Chiropractic Clinic of any changes in my health status or above information.

Fees are payable at the time of service, unless other arrangements have been made in advance. I hereby give permission for treatment.

Patient's Signature: _____ Date: _____

Parent/ Legal Guardian (If Minor): _____ Date: _____

Coordinated Care Communications

Dr. Kamego feels that it is very important that we coordinate with your doctors and keep them up to date on your treatment and progress here at our office. Please fill in any and all information, by doing so I give authorization to Kamego Chiropractic Clinic to release my health care information to the offices and / or providers below.

General Physician:
Address:
City, State, Zip:
Phone Number:

Podiatrist:
Address:
City, State, Zip:
Phone Number:

OB/GYN:
Address:
City, State, Zip:
Phone Number:

Other:
Address:
City, State, Zip:
Phone Number: