

Welcome

1. Patient Name _____ Date _____ SS# _____
Address _____ City _____ Zip _____
Sex M F Age _____ D.O.B. _____
Home Phone _____ Work Phone _____ **Email:** _____
Best time and place to reach you _____
Are you Single Married Widowed Separated Divorced
Your Employer _____ Occupation _____
Business Address _____ City _____ Zip _____
Spouse's Name _____ Spouses D.O.B. _____ SS# _____
Spouse's Employer _____ Spouse's Occupation _____
In case of emergency, contact _____ Phone _____

2. Responsible Party

Who is responsible for this account? _____
Relationship to patient _____ Phone _____
How do you plan on paying for your care?
1. Payment at Time of Service. This plan is available to everyone. Under this plan we will provide you with a discount off our regular fee schedule. Note: If you do not pay at the time of service, we are required by law to charge you our regular fee schedule.
2. Insurance Policy Coverage

3. Primary Insurance Co. _____ ID# _____ Grp# _____

Do you have additional insurance? No Yes If yes, complete the following:

Name of insured _____ Relationship to patient _____ D.O.B. _____ SS# _____

Secondary Insurance Co. _____ ID# _____ Grp# _____

Insurance Policy Coverage – Please read the following policies:

1. We may accept assignment of insurance benefits. However, the balance incurred is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your company. It is in your best interest to be familiar with your policy.
2. As a courtesy to you, we submit claims to your insurance company one time. Your insurance company may require additional information from you before they will pay or deny a claim. It is your responsibility to provide this information promptly.
3. Any insurance payment mailed to you should be brought or sent to our office, along with attached insurance statements, within 3 days. Any monies kept without our consent or approval will be considered theft.
4. Our practice is committed to providing the highest quality affordable care for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.
5. Our practice only performs those services which are medically necessary. You are responsible for payment regardless of any insurance company's arbitrary determination of medical necessity.
6. All deductibles and co-pays are due at the time of service.

I have read and understand the above insurance policies.

Patient's signature _____ Date _____

4. Assignment and release of benefits.

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly To Dr. Brad Pearce all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Relationship _____ Date _____

5. Accident information

Is your condition due to an accident? yes No Date of Accident _____

Type of Accident: Auto Work Other _____

Attorney Name (if applicable) _____ Phone _____

6. Current Health History

Please check any of the following that you are **presently** experiencing.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Tingling/Numbness in Arms | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Tingling/Numbness in Legs | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Allergies | _____ |

Which of the above are you seeking treatment for? _____

Does your problem prevent you from doing anything you'd like to do? _____

Are you pregnant Yes No Due Date _____

7. Family History

Mother – Living? Yes No Age _____ Father-Living? Yes No Age _____

Please check all that apply regarding family

	Mother	Father	Siblings	Spouse	Children
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Kidney Problems	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Back Pain	_____	_____	_____	_____	_____
Neck Pain	_____	_____	_____	_____	_____
Headaches	_____	_____	_____	_____	_____
Carpal Tunnel	_____	_____	_____	_____	_____
Ear Infections	_____	_____	_____	_____	_____

8. Past Health History

Surgeries, Traumas, Illnesses

- Falls _____ Date(s) _____
- Head Injuries _____ Date(s) _____
- Broken Bones _____ Date(s) _____
- Dislocations _____ Date(s) _____
- Surgeries _____ Date(s) _____
- Auto Accidents _____ Date(s) _____
- Serious Illness _____ Date(s) _____

Please inform us of any other health conditions we should be aware of _____

9. Daily Habits

- Exercise None Moderate Heavy
- Work Activity Sitting Standing Heavy Lifting
- Habits Smoking _____ Packs per day Alcohol _____ Drinks per day
- Medications _____
- Allergies _____
- Vitamins/Herbs/Minerals _____