PATIENT INFORMATION

Full Name_____ Gender M ☐ F ☐ Home Phone_____

Address_____ City_____ State_____ Zip_____

Age_____ Birth Date_____ Marital Status (circle one) S M W D Sep No. Children_____

SS# _____ Driver's License # _____

Patient Employer_____ Patient Occupation_____Years on job_____

Employer Address_____ City_____ State_____ Zip_____

Work Phone_____Do you have health insurance at your work? Yes ☐ No ☐

Insurance company _____Plan/Group # _____

Name of spouse, parent or guardian _____ Age_____ Birth Date_____ SS#_____

Spouse's Employer_____Occupation_____ Years on job_____

Employer Address_____ City_____ State_____ Zip_____

Work Phone_____Does your spouse have health insurance at your work? Yes ☐ No ☐

Insurance company _____Plan/Group # _____

How did you find out about our office?_____

Describe the major complaints that brought you to our office? _____

_____

Is your condition due to an accident/injury? Yes ☐ No ☐ Date of accident/injury:_____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered and non-covered. If the doctor is a contracted provider for my managed plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18%) annually.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo static copy of this agreement shall serve as the original.

Patient's Signature_____ Date_____

Spouse's or Guardian's Signature _____ Date_____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee as time permits.

Payment options (Please Indicate): ☐Cash ☐Check ☐MasterCard ☐Visa

Please allow the staff to make a photo copy of your Driver's License and all insurance cards

MEDICAL HISTORY

Have you been treated for any conditions in the last year? Yes ☐ No ☐

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? Yes ☐ No ☐

Have you had x-rays taken? Yes ☐ No ☐ If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, ect.) _____

_____

What vitamins, minerals, or herbs do you currently take? (Please list dosage and amounts, ect.) _____

_____

Have you ever:	**Yes**	**No**	**Briefly Explain**
Broken Bones?	☐	☐	
Been Hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had Sprains/Strains	☐	☐	
Been struck unconscious?	☐	☐	
Had Surgery?	☐	☐	

Family History – List past & present family members health conditions (Ex. Heart disease, cancer, diabetes, arthritis)

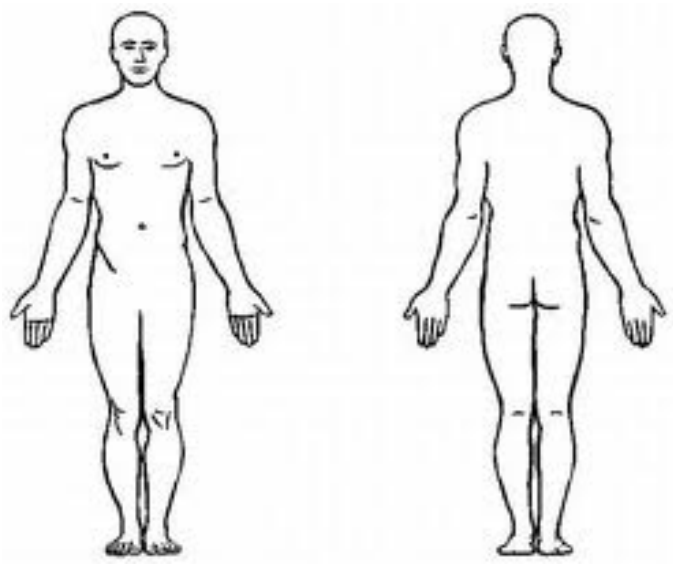
Do you experience pain everyday?	**Yes**	**No**
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐
What activities aggravate your symptoms?	☐	☐

Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Place an (x) if you have suffered from:	
	Alcoholism
	Allergies
	Anemia
	Arteriosclerosis
	Arthritis
	Asthma
	Back Pain
	Breast Lump
	Bronchitis
	Bruise Easily
	Cancer
	Chest Pain/Condition
	Cold Extremities
	Constipation
	Cramps
	Depression
	Diabetes
	Digestion Problems
	Dizziness
	Ears Ring
	Excessive Menstruation
	Eye Pain or Difficulties
	Fatigue
	Frequent Urination
	Headache
	Hemorrhoids
	High Blood Pressure
	Hot Flashes
	Irregular Heart Beat
	Irregular Cycle
	Kidney Infection
	Kidney Stones
	Loss of memory
	Loss of balance
	Loss of smell
	Loss of taste
	Neck Pain or Stiffness
	Nervousness
	Nosebleeds
	Pacemaker
	Polio
	Poor Posture
	Prostate Trouble
	Sciatica
	Shortness of Breath
	Sinus Infection
	Sleep problems or insomnia
	Spinal Curvatures
	Stroke
	Swelling of ankles
	Swollen joints
	Thyroid Condition
	Tuberculosis
	Ulcers
	Varicose Veins
	Venereal Disease
	Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

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



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments, and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient names below for which I am legally responsible) by the licensed doctor(s) of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to; fractures, dislocations, muscle strain, costovertebral strains and seperations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Printed name of patient

_____ _____

Signature of patient Date

_____ _____

Signature of patient's representative (if minor) Date

Occupational Health Services LLC
Jerome Greene, DC

NOTICE OF FINANCIAL OBLIGATION

Please understand that it is your responsibility as a patient to provide us with all the information needed to file your insurance claim at the time of service. Dr. Greene is a Blue Cross Blue Shield Preferred Provider; therefore, we will submit all Blue Cross and Blue Shield claims for you. If you have a copay or you are meeting you deductible payment for services is due at the time of each visit. We will verify your insurance benefits, but we will not guarantee your insurance will cover your services. Please remember that your insurance contract s between you, the patient, and your insurance carrier. We are not party to that contract. You will be responsible for all amounts that are not paid by your insurance carrier. As a healthcare provider, we will take only contracted reasonable and customary write-offs.

Insurance from any other carrier besides Blue Cross Blue Shield will not be submitted for you, but upon request a claim form can be emailed to you for you to submit to your insurance company.

- **AUTO ACCIDENT OR PERSONAL INJURY** – We will file claims for you but you are ultimately responsible for all amounts that are not paid by the automobile insurance. The automobile insurance company will send you forms that must be completed by you and send back to their company as soon as possible. If this is not done it will delay payment and you will be responsible for the balance.

- **WORKERS COMPENSATION** – An accident report must be filled with your employer prior to your first visit. We will contact you employer to verify that the accident was work related. With verification from our employer, we will submit the claim to the worm comp carrier, without it, you will be responsible for paying for your health care at the time of service.

- **NO HEALTH COVERAGE** – You are responsible to pay 100% of your visit in full at each service unless other payment arrangements have been made. We accept cash, check, debit card, Visa, MasterCard, and health savings plan cards.

I have read the above and understand the office policy that regardless of insurance status, I am ultimately responsible for the balance on my account for all professional services rendered.

_____ _____

Patient/Guardian Signature Date

ANNUAL INFORMATION UPDATE MANDATED
FOR GOVERNMENT ELECTRONIC HEALTH RECORDS

CONTACT INFORMATION: (Please put an X by your refered way of contact)

___ Home Phone: _____

___ Cell Phone: _____

___ Work Phone: _____

Email: _____

PERSONAL INFORMATION: (Please Circle)

WHITE

HISPANIC OR LATINO

ASIAN

BLACK OR AFRICAN AMERICAN

AMERICAN INDIAN OR ALASKAN NATIVE

NATIVE HAWAIIAN OR OTHER PACIFIC ISALNDER

MARITAL STATUS: (Please circle) M S D W

MEDICAL INFORMATION:

Current medications and approximate start dates: _____

_____

_____

Allergies: (Example: Food, Drug, Environmental) _____

_____

_____

Surgeries & approximate dates: _____

_____

_____

Hospitalizations & approximate dates: _____

_____

_____

Major illnesses & approximate dates: _____

_____

_____

SMOKING STATUS: (Please circle) NEVER CUURENTLY FORMER

SIGNATURE_____DATE_____

***PLEASE BE SURE TO NOTIFY US IF YOU HAVE HAD A CHANGE OF ADDRESS OR INSURANCE CARRIER WITHIN THE LAST YEAR.**