PATIENT INFORMATION

Full Name_____ Gender M☐ F☐ Birth Date _____

Address_____ City_____ State_____ Zip_____

Cell# _____ Home#_____ Work#_____

Email_____ Marital Status S☐ M☐ W☐ D☐ Sep☐

Insurance company _____ Last 4 digist of SSN _____

Patient Employer_____ Patient Occupation_____Years on job ____

Employer Address_____City_____ State_____ Zip_____

Name of spouse, parent or guardian _____ Birth Date_____ Last 4 digist of SSN _____

Spouse's Employer_____Work Phone #_____Years on job_____

Employer Address_____ City_____ State_____ Zip_____

Responsible Party for Bill: Name_____ Address_____

City_____ State_____ Zip_____

Emergency Contact: Name_____ Phone #_____

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 _____

Notice of Receipt of Privacy Notice from Occupational Health Services, LLC

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from the offices of Occupational Health Serivces, LLC. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Prvacy Practices is subject to change. If the Notice is changes, you may obtain a revised copy by visiting our website at chirobygreene.com or on request from our staff.

I (we) acknowledge receipt of the Notice of Privacy Practices from Occupational Health Services, LLC.

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_____

Parent or Guardian's Signature _____ Date_____

*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, etc.):
What vitamins, minerals, or herbs do you currently take? (Please list dosage and amounts, etc.):

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)

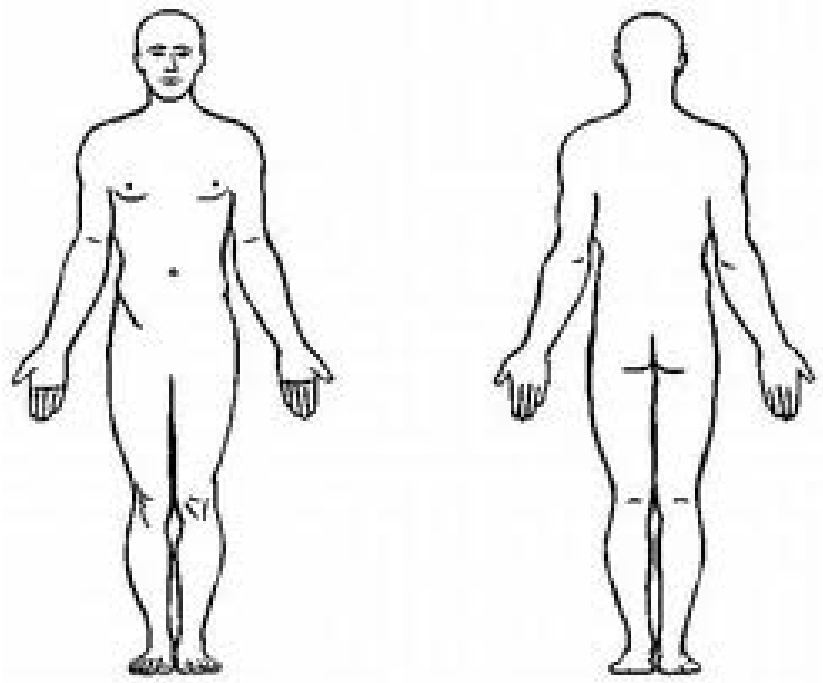
Do you experience pain everyday:	**Yes**	**No**
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?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

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

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.

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.

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