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burkhartchappchiropractic.com

CONFIDENTIAL APPLICATION FOR EVALUATION & TREATMENT

To better serve you, please be as thorough as possible in completing the application. Thank you.

Patient Information

Last Name:________________________ First Name:______________________ MI:____ Date:________________
Address____Apt #____________________
City____State__________________ Zip ______________
Check if you are: __ Married __ Single __ Divorced __ Widowed
Date Of Birth ____________________________Your Age__________ S.S.# ________________________________

Home Phone ___________________Work Phone ___________________Cell Phone __________________________
Email Address: ____

Emergency Contact Name and Phone: ____
Primary Care Provider Name and Phone: ____
How would you prefer us to contact you for follow up calls, appointment reminders/reschedules?

___ Home Phone ___ Cell Phone ___ Work Phone __ Email

Where are you employed? ____
Occupation/Job Description ____

How did you hear about our office/who were you referred by (check all that apply)? _________________________
_Yellow Pages _Internet Search _Family/Friend Referral _Television
_Radio Ad _Community Event _Walk-by/Drive-by _Other_____________

Guarantor Information (Responsible Party)

If the patient and the guarantor are the same, please check here ☐ Relationship to Patient ___________
Last Name: ____________________ First Name: _________________ Middle Name:_______________
Gurantor's DOB: _______________ Guarantor's Gender: ___ Male ___ Female
Drivers License No: ______________________________ Phone: __________________________
Address____Apt #___________
City____State________ Zip ______________

Office Use Only:
Pt Chart #: __________
Input By: ____________

Additional Patient Demographic Information

Name: ____________________

In order to remain in compliance with federal standards, we need you to please answer the following questions that relate to race, origin, language, smoking, etc:

Height: ______ Weight: ______ Are you left or right handed? ____ Left ____ Right
Check which language you prefer: __ English __ Spanish __Other___________________________

Race: __ White __ Black or African American __ Asian
__ Native Hawaiian or Other Pacific Islander
__American Indian or Alaska Native Other ________________________
__I do not wish to provide this information

Ethnicity: __ Hispanic or Latino __ Non-Hispanic or Non-Latino
__Other _________________________________
__ I do not wish to provide this information

Smoking Status: __Current every day smoker __Current some day smoker
__Former Smoker __Never Smoker
If Applicable: Date or year started smoking: ___________ Date or year stopped smoking: ___________

MEDICAL HISTORY-CHIROPRACTIC EVALUATION

1. What brings you into our office (Please list your major problem, complaint(s), and related symptoms in as much detail as possible)? ____
____
2. Is your problem or complaint(s) the result of an event or injury? __Yes __No
If yes, please check one: __Auto Related __Work Related __ Home Related __Other_____________________
Description of Injury____
3. Date when you first noticed symptoms: _______________ The symptoms began: __ Suddenly __Gradually
Have you ever received treatment for this or any other similar condition before? __Yes __No
If so, please describe when, where, and what results were: ____
____
4. Have you undergone any surgery for this or any other condition? If so, please describe: ______________________
____
5. Do you feel your condition is: __Improving __Staying the same __Getting worse
6. Have you ever broken any bones? ____________ What? ________________________ How? _______________
____
7. Please list any drugs or medication that you currently take: __ Not currently prescribed to any medications
What? ______________________________ _______ mg How often? ___________________
What? ______________________________ _______ mg How often? ___________________
What? ______________________________ _______ mg How often? ___________________
What? ______________________________ _______ mg How often? ___________________

8. Do you have any medication allergies (check one)? __ No known medication allergies
__ Yes What? ____

9. Have you ever consulted a Doctor of Chiropractic in the past? __Yes __No
If yes, whom: ______________________________ Date of last visit __________________________

10. Do you have any children? __Yes __No If yes, how many? ___________

Is there any possibility you are pregnant? __Yes __No

11. Do you use: __Tobacco __Alcohol __Coffee __Other____

OFFICE POLICIES:

1. I understand that the doctor is not responsible for any action by my insurance carrier with regard to policy or payment, and I accept full responsibility for any charges incurred by me for services rendered. Fees are payable when examination, x-rays, or treatments are rendered, **unless other arrangements are made in advance.** In consideration of Burkhart & Chapp Chiropractic P.L.C. extending credit, I do hereby agree jointly and severally to pay for all services and merchandise supplied to me. I agree to pay 1% interest on any overdue balance each month. In the event it becomes necessary to place the account with any attorney or agency for collection, I agree to pay all costs of collection including reasonable attorney's fees. In the event of litigation heron, I consent to venue in the courts located in Kent County, MI. I further waive the right to a jury trial in any action concerning this agreement or its related subject matter. I agree to immediately notify Burkhart & Chapp Chiropractic of any change of address and/or phone. I personally guarantee payment to Burkhart & Chapp Chiropractic P.L.C. for goods and services.
2. I understand that by receiving chiropractic treatment, I have not been guaranteed a remedy for any or all of my subjective complaints, and there may be side effects or complications to the treatment I receive. Please read the informed consent document and/or ask your doctor to review the potential benefits and risks of chiropractic care
3. I hereby authorize the doctor to release, as he/she deems necessary, any and all information acquired in the course of my examination and/or treatment.
4. If billing a participating insurance carrier, I hereby authorize my insurance company to pay this office directly. Services that are not billed to my insurance carrier will be paid at the time of service.
5. I understand that I am responsible to monitor my children at all times while visiting the office.

MISSED/CANCELLED APPOINTMENT CHARGE
If you fail to cancel or miss your scheduled appointment without giving us 24-hour notice, you may be charged our standard office fee.

RETURNED CHECK CHARGE: $25.00

POLICY REGARDING RECORDS
We release X-rays in a digital compact disk format directly to the patient or to a physician, or hospital of the patient's choosing. A release must be signed by the patient and all records will be sent to the requested individual or institution.

I HAVE READ AND UNDERSTAND THIS COMPLETELY

____

Patient Signature Date Doctor Signature Date

AUTHORIZATION TO TREAT A MINOR
As a parent or legal guardian, I authorize the doctor to render necessary examination and treatment to:
________________________________ and will be responsible for payment of services rendered.

Signature: ____ Date:__________