



608-437-5585

P.O. Box 46-1505 Hwy 18-151, Mt. Horeb, WI 53572

Doctor _____ Date _____

Payment _____ Insurance or Cash

CONFIDENTIAL PATIENT INFORMATION FORM - PLEASE PRINT

Full Name _____

Name of wife, husband or guardian _____

Address _____

(Residence and mailing) (City) (State) (Zip Code)

Phone (____) _____ Cell Phone (____) _____ Email: _____

Married __ Single __ Widow(er) __ # of children _____ Are you pregnant? _____ SS# _____

Date of birth. _____ Age _____ Height _____ ft _____ in. Weight _____ lbs

Occupation _____

Employer _____ Phone(____) _____

Address _____

Emergency Contact _____ Phone (____) _____

Whom may we thank for referring you to us/how did you hear about us? _____

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

List medical doctors seen within past year:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

Date of last physical examination _____

List all surgeries:

Type _____ When _____

Type _____ When _____

Type _____ When _____

Past accidents or injuries:

Type _____ When _____ Hospitalized? Yes _____ No _____

Type _____ When _____ Hospitalized? Yes _____ No _____

Type _____ When _____ Hospitalized? Yes _____ No _____

List medications and/or vitamins & minerals you are taking:

Type _____ For _____ How long _____

Type _____ For _____ How long _____

Type _____ For _____ How long _____

Past and Present Conditions

Below are listed common symptoms, which may suggest the presence of an ailment, involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	Musculoskeletal	Present
<input type="checkbox"/>	Neck pain	<input type="checkbox"/>
<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>
<input type="checkbox"/>	Pain in upper arm or elbow	<input type="checkbox"/>
<input type="checkbox"/>	Hand pain	<input type="checkbox"/>
<input type="checkbox"/>	Upper back pain	<input type="checkbox"/>
<input type="checkbox"/>	Low back pain	<input type="checkbox"/>
<input type="checkbox"/>	Leg pain	<input type="checkbox"/>
<input type="checkbox"/>	Knee pain	<input type="checkbox"/>
<input type="checkbox"/>	Pain in ankle or foot	<input type="checkbox"/>
<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>
<input type="checkbox"/>	Swelling in joints (list joints)	<input type="checkbox"/>
<input type="checkbox"/>	Stiffness of joints (list joints)	<input type="checkbox"/>

Past	Nervous System	Present
<input type="checkbox"/>	Depression	<input type="checkbox"/>
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>
<input type="checkbox"/>	Fainting	<input type="checkbox"/>
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>
<input type="checkbox"/>	Headache	<input type="checkbox"/>
<input type="checkbox"/>	Muscular incoordination	<input type="checkbox"/>
<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>
<input type="checkbox"/>	Tinnitus (ear noises)	<input type="checkbox"/>
<input type="checkbox"/>	Ear pain	<input type="checkbox"/>
<input type="checkbox"/>	Impaired vision	<input type="checkbox"/>
<input type="checkbox"/>	Eye pain	<input type="checkbox"/>
<input type="checkbox"/>	Paralysis	<input type="checkbox"/>

Past	Cardiovascular	Present
<input type="checkbox"/>	Rapid heart beat	<input type="checkbox"/>
<input type="checkbox"/>	Chest pains	<input type="checkbox"/>

Past	Endocrine	Present
<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>
<input type="checkbox"/>	Abnormal weight gain	<input type="checkbox"/>
<input type="checkbox"/>	Abnormal weight loss	<input type="checkbox"/>

Past	Respiratory	Present
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>
<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>
<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>
<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>

Past	Gynecologic	Present
<input type="checkbox"/>	Cramps	<input type="checkbox"/>
<input type="checkbox"/>	Irregular menstrual flow	<input type="checkbox"/>
<input type="checkbox"/>	Spotting	<input type="checkbox"/>
<input type="checkbox"/>	Menopausal symptoms	<input type="checkbox"/>

Past	Genito-Urinary	Present
<input type="checkbox"/>	Painful urination	<input type="checkbox"/>
<input type="checkbox"/>	Loss of bladder control	<input type="checkbox"/>
<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>
<input type="checkbox"/>	Urethral discharge	<input type="checkbox"/>

Past	GI Tract	Present
<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>
<input type="checkbox"/>	Difficult swallowing	<input type="checkbox"/>
<input type="checkbox"/>	Heartburn/indigestion	<input type="checkbox"/>
<input type="checkbox"/>	Constipation	<input type="checkbox"/>
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>

Past	Skin	Present
<input type="checkbox"/>	Rash	<input type="checkbox"/>
<input type="checkbox"/>	Dermatitis or eczema	<input type="checkbox"/>
<input type="checkbox"/>	Persistent itching	<input type="checkbox"/>

Please check any of the following that apply to you.

<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	Tranquilizers/Sedatives
<input type="checkbox"/>	Laxatives
<input type="checkbox"/>	Coffee, cups/day _____
<input type="checkbox"/>	Regular soda, cans/day _____
<input type="checkbox"/>	Diet soda, cans/day _____
<input type="checkbox"/>	Water _____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Past	Condition	Present
<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
<input type="checkbox"/>	Rheumatic heart disease	<input type="checkbox"/>
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
<input type="checkbox"/>	Angina	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack	<input type="checkbox"/>
<input type="checkbox"/>	Stroke	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>
<input type="checkbox"/>	Gallbladder	<input type="checkbox"/>
<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<input type="checkbox"/>	HIV positive/AIDS	<input type="checkbox"/>

Past	Condition	Present
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
<input type="checkbox"/>	Drug or alcohol dependency	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	Ulcer	<input type="checkbox"/>
<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>
<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>
<input type="checkbox"/>	Allergies	<input type="checkbox"/>
<input type="checkbox"/>	Other _____	<input type="checkbox"/>
<input type="checkbox"/>	Other _____	<input type="checkbox"/>

GONSTEAD CLINIC OF CHIROPRACTIC PATIENT REGISTRATION AGREEMENT

Name: _____ Address: _____ Phone#: _____ E-mail: _____

YOUR TREATMENT BY US

- I consent to the customary examinations, tests and procedures performed at or by the Gonstead Clinic of Chiropractic (the "Clinic") and to routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others.

YOUR PRIVACY:

We are very concerned with protecting your privacy. We have, and always will, respect the privacy of your medical information. Our Privacy Practices Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your medical information, and of other important matters about your medical information.

- I acknowledge receipt of your Privacy Practices Notice and Marketing Authorization, and have had the opportunity to read them before signing this Agreement.
- I consent to your use and disclosure of my medical records to carry out treatment, payment activities, and health care operations as set forth in your Privacy Practices Notice. I agree that you may contact me with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to me by phone, and may leave messages on my answering machine or with the individuals at my home or place of employment.
- I consent to your disclosure of my medical records to the following persons, including those involved in my care or payment for that care (check those that apply): My spouse Any member of my immediate family Other: _____

This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to us. Revocation of this consent will not affect any action we took in reliance on this consent before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

WE WILL FILE YOUR INSURANCE FOR YOU. We will prepare any necessary reports and forms to assist you in making collection from the insurance company. Any amount paid directly to the GONSTEAD CLINIC OF CHIROPRACTIC will be credited to your account upon receipt by us.

- I hereby assign the benefits payable for chiropractic services to Clinic and authorize the Clinic to submit a claim to third party payers for payment on my behalf.
- I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

OUR PAYMENT POLICY

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. All services rendered by the Clinic are charged directly to you, the client. You are personally and fully responsible for all payments, regardless of whether or not we accept insurance assignment.

- I agree to keep the balance I owe the Clinic at no more than \$ 150, unless we agree in writing to a higher balance. If I do not have insurance, I agree to pay all amounts owed at the time a service is rendered or at the end of each week. If I am an insurance assignment patient, I agree to pay my deductible in full and pay my co-insurance at the time a service is rendered or that week.
- I agree to be responsible for legal fees, collection fees, and any other expenses incurred in collecting the Clinic's account.
Returned checks will have a \$20.00 fee and balances over 30 days may be subject to interest charges of 1.5% per month.

We are committed to great service...and expect to be fairly paid for it. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient or Personal Representative

Date

Personal Representative and Relationship to Patient

Treatment of a Minor, I as legal guardian of patient do authorize appropriate chiropractic treatment.

Signature

Date