Please allow our staff to photocopy your driver's license and insurance card. All information you supply is confidential.

Whom may we thank for referring you to our office? _____

APPLICATION FOR CARE AT GEM CITY CHIROPRACTIC

Today's Date: _____

Patient's Demographics:

Name: _____ Birth Date: __/__/__ Age: ____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Work #: _____

Occupation: _____ Employer: _____

Would you like to receive appointment reminders via text messaging? Yes No

Email address: _____

Marital Status: M S D W Name of Spouse or Significant Other: _____

Number of children _____

Health Insurance: YES or NO

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: _____

Chief complaint: _____

Secondary Complaint(s) or symptoms associated: _____

When did the problem(s) begin? _____ Is your problem the result of ANY type of accident **YES** or **NO**.

If Yes identify type: Auto Work Home Other (please explain) _____

Date of Accident: _____/_____/_____ approximately what time of day? _____am _____pm

Have you reported this accident to anyone? No / Yes If yes, when? _____

Other forms of treatment tried? _____, and who provided it _____

_____ When? _____

What were the results? Favorable Unfavorable... please explain: _____

_____

PAST HISTORY

1: If you have ever experienced any of the following conditions at any time please mark with an **X**:

____Moving Vehicle Accident	____Injury: Lifting, Falling etc	____Broken Bones
____Heart Attack	____Convulsions / Epilepsy	____Vascular Issues
____Disability	____Jaw Pain / TMJ	____Tremors
____Stroke	____Cancer	

SOCIAL HISTORY

1: Height_____ Weight_____ Blood Pressure_____/_____
2: Smoking: Cigars Pipe Cigarettes..... How Often? Daily Weekends Occasionally Never
3: Alcoholic Beverage: Consumption occurs.... Daily Weekends Occasionally Never
4: Recreational Drug use: Daily Weekends Occasionally Never
5: List Prescription drugs you take:

_____

_____

6: Allergies to Prescription Drugs:

_____

_____

7: List Vitamins & Supplements / Non-Prescription drugs you take:

_____

_____

FAMILY HISTORY

1: Does anyone in your family suffer the same condition(s) you currently have? **No /Yes** (if yes whom)

Grandmother Grandfather Mother Father Sister(s) Brother(s) Son(s) Daughter(s)

Have they ever been treated for their condition? **No Yes I don't know**

2: Any other hereditary conditions the doctor should be aware of? **No Yes**: _____

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO GEM CITY CHIROPRACTIC FOR ALL BENEFITS WHICH MAY BE PAYABLE UNDER A HEALTHCARE PLAN OR FROM ANY OTHER COLLATERAL SOURCES. I AUTHORIZE UTILIZATION OF THIS APPLICATION OR COPIES FOR THE PURPOSE OF PROCESSING CLAIMS AND EFFECTING PAYMENTS. I ALSO FURTHER ACKNOWLEDGE THAT THIS ASSIGNMENT OF BENEFITS DOES NOT IN ANY WAY RELIEVE ME OF PAYMENT LIABILITY AND THAT I WILL REMAIN FINANCIALLY RESPONSIBLE TO GEM CITY CHIROPRACTIC FOR ANY AND ALL SERVICES AT THE OFFICE.

_____ ____/____/____

Patient or Authorized Person's Signature **Date Completed**

General Pain Index Questionnaire

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your ***typical*** level of pain affects these six categories of activities.

1. FAMILY/ AT HOME RESPONSIBILITIES SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. RECREATION INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. SOCIAL ACTIVITIES INCLUDING PARTIES, THEATER, CONCERTS, DINING-OUT AND ATTENDING OTHER SOCIAL FUNCTIONS-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. EMPLOYMENT INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. SELF-CARE SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. LIFE-SUPPORT ACTIVITIES SUCH AS EATING AND SLEEPING-

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

Patient Name _____ Date _____

SCORE _____ (60) BENCHMARK =5 _____

Patient.Name: _____ Doctor : _____ Date: _____

IMPORTANT Please x all present symptoms

Rate pain by intensity levels using scale from 0-10 absent 0 1 2 3 4 5 6 7 8 9 10 excruciating pain

HEAD:
__ Headache (R/L) rate pain (0-10)
__ sinus (allergy) (0-10)
__ entire head (0-10)
__ back of head (0-10)
__ forehead (0-10)
__ temples (0-10)
__ migraine (0-10)
__ Head feels heavy
__ Loss of memory
__ Light headedness
__ Fainting

__ light bothers eyes
__ Blurred vision
__ Double vision
__ Loss of vision
__ Loss of taste
__ Loss of balance
__ Dizziness
__ Loss of hearing
__ Pain in ears (0-10)
__ Ringing in ears
__ Buzzing in ears

NECK:
__ Pain in neck (R/L) (0-10)
__ Neck pain with movement
__forward (0-10)
__ backward (0-10)
__ low back pain (R/L) (0-10)
__ bending right (0-10)
__ bending left (0-10)
__ turning right (0-10)
__ turning left (0-10)
__ Pinched nerve in neck
__ Neck feels out of place
__ Neck muscle spasms
__ Neck grinding sounds
__ Neck popping sounds
__ Muscle spasms in shoulders
__ Arthritis in neck

MIDBACK (blade area)
__ Mid-back pain (R/L) (0-10)
__ Pain in between blades (R/L) (0-10)
__ Sharp stabbing
__ Dull ache
__ Pain in kidney area (0-10)
__ Muscle spasms (R/L)

ARMS & HANDS:
__ Pain in upper arm (R/L) (0-10)
__ Pain in elbow (R/L) (0-10)
__ Pain in forearm (R/L) (0-10)
Pain in hands (R/L) (0-10)
Pain in fingers (R/L) (0-10)
__ Pins & needles sensation
___ arms (R/L)
___ hands/fingers (R/L)
___ Numbness
__arms (R/L)
__ hands/fingers (R/L)
__ Pain aggravated by movement
__Tennis elbow (R/L) __ Hands feet cold
__ loss of grip strength (R/L) __ Arthritis : __ shoulders (R/L) __elbow (R/L) __ fingers (R/L)

SHOULDER JOINTS:
__ Pain in shoulder joint (R/L) (0-10)
__ Pain across shoulders (0-10)
__ Bursitis (R/L)
__ Arthritis (R/L)
__ Can't raise arm
__ above shoulder level
__ over head
__ Tension in shoulders
__ Pinched nerve in shoulder (R/L)
__ Muscle spasms in shoulders

CHEST:
__ Chest pain (0-10)
__ Shortness of breath
__ Pain around ribs (0-10)
__ Breast pain (0-10)
__ Dimpled/orange peel breast
__ Irregular heartbeat

ABDOMEN:
__ Nervous stomach
__ Nausea
__ Gas
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Foods can't eat_____

LOW BACK:
__Upper lumbar (R/L) (0-10)
__Lower lumbar (R/L) (0-10)
__ Sacroiliac (R/L) (0-10)
__ Low back pain is worse when:
__working (0-10)
__ lifting (0-10)
__ stooping (0-10)
__ standing (0-10)
__ sitting (0-10)
__ bending (0-10)
__ coughing (0-10)
__lying down (sleeping)(0-10)
__ walking (0-10)
__ low back feel better _____
__ slipped disc
__ pain from front to back
__ low back feels out of place
__ muscle spasms
__ arthritis

HIPS, LEGS, & FEET:
__ Pain in buttocks (R/L) (0-10)
__ Pain in hip joints (R/L) (0-10)
__ Pain down leg (R/L) (0-10)
__ Knee pain (R/L)
___ inside/medial (R/L) (0-10)
___ outside/lateral (R/L) (0-10)
____ leg cramps (R/L) (0-10)
___ foot cramps (R/L) (0-10)
___ Pins & Needles sensation in legs (R/L)
___ Numbness
__ legs (R/L)
__ feet (R/L)
__ toes (R/L)
__ swelling
__ legs (R/L) __ ankles (R/L) __ feet (R/L) __ feet feel cold (R/L)

WOMEN ONLY:
__ Menstrual pain (where)_____ 0-10
__ Cramping (severe/mod/mild)
__ Irregularity
__ Cycle _____ days
__ Birth control _____ (type)
__ Hysterectomy _____ (year)
__ Complete
__ Partial
__ Hormone replacement therapy
__ Genital cancer
__ Discharge
__color
Treatment _____
___ Tumors
___ Fibroids
___ Menopause
__ Premenstrual Syndrome
__ Abortions

MEN ONLY:
__ Frequent urination
__ Difficulty in starting
__ Difficulty in emptying completely
__ Frequent night urination
__ Prostate cancer (year diagnosed____)
__ treatment_____
__ Enlarged prostate

GENERAL:
__ Nervousness
__ Irritable
__ Depressed
__ Fatigue
__ Feel run-down
__ Arthritis
__ Osteoarthritis
where _____

__ Rheumatoid
__ Gout
__ Fibromyalgia
__ Diabetes
__ insulin dependant
__ non insulin dependant
__ blood sugar
control thru diet and exercise only
__ Hypoglycemia
__ normal hours of sleep _____
__ lost hours of sleep_____
__ weight gain ___lbs. 1/3/6/12 months
__ weight loss ___lbs. 1/3/6/12 months
__ soda__ 12oz cans/day type____
__ cola/non-cola/diet/caffeine free
__ coffee/tea__cups/day __ decaf.
__ cigarettes____ packs/day
__ vitamins (list) _____
_____
_____

REMARKS:
_____
_____

Patient Signature: _____

Financial Policy

ASSIGNMENT OF BENEFITS

I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Dr. Becky A. Grimm, D.C and/or Dr. Nicole Paxton, D.C.

RELEASE OF INFORMATION

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Not with standing denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

GEM CITY CHIROPRACTIC, LLC (GCC, LLC)

PRIVACY POLICY

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying GCC, LLC, in writing, except to the extent GCC, LLC has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosure that GCC, LLC may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request GCC, LLC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. GCC, LLC is not required to agree to requested restrictions. If GCC, LLC agrees to the requested restriction, GCC, LLC will honor the request and it will e binding on the office.

I hereby consent to the use and disclosure by Gem City Chiropractic, LLC, its workforce, and its business associated of my protected health information for the purpose of treatment, payment, and health care operations.

Signature Date

Guardian Signature Relation to Patient Date

Gem City Chiropractic, LLC

FINANCIAL POLICY - GEM CITY CHIROPRACTIC. LLC

FINANCIAL POLICY

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE - We request that 100% of the first visit and subsequent visits be paid at the time of the visit unless other arrangements have been pre- arranged and agreed upon. A payment plan can be established in writing.

GROUP OR INDIVIDUAL INSURANCE - When possible, we will call to verify benefits on you insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductible or co-pays.

"ON THE JOB" INJURY (Workers Compensation) If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS - Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care in initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

MEDICARE - We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE - Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

INSURANCE ONE TIME AUTORIZATION

I understand that my insurance is an arrangement between myself and my insurance company. NOT between Dr. Grimm or Dr. Paxton and my insurance company. I request that Gem City Chiropractic, LLC prepare the customary forms at no charge so that my insurance company can process my claim(s). I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Becky A. Grimm, D.C and/or Dr. Nicole G. Paxton, D.C., that fees will be due and payable immediately.

Gem City Chiropractic, LLC.

Signature Date

Guardian Signature Relationship to Patient Date