Welcome to Mack Chiropractic Health Center

Date _____

SS# _____

Patient Name _____
First Last MI

Home
Address _____ City _____ State _____

Zip _____ E-mail _____

Billing
Address (if diff.) _____ City _____ State _____

Zip _____

Home Phone _____ Cell Phone _____

Sex M / F Age _____ Birthdate _____

__ Married __ Widowed __ Single __ Minor __ Separated __ Divorced __ Partnered for _____ yrs

Occupation _____

Employer/School _____

Employer/School Address _____

Employer/School Phone _____

Primary Care Physician _____ Phone _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home # _____ Cell # _____ Work # _____

INSURANCE (SUBSCRIBER'S INFORMATION):

Name _____ Relationship to Patient _____ Birthdate _____

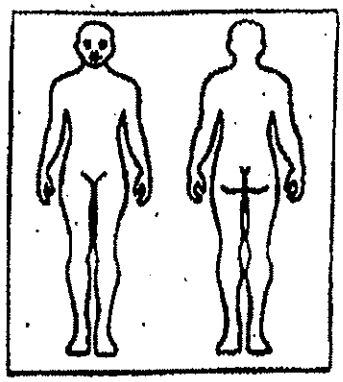
ID# _____

Is patient covered by additional insurance? Y / N

Subscriber's Name _____ Relationship to Patient _____

Birthdate _____ ID# _____

Patient Condition



Mark an X on the diagram pertaining to the area(s)

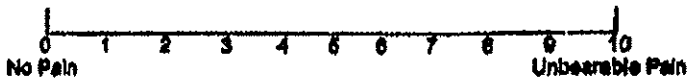
Where you continue to have pain, and where it may travel to.

 # 1 Complaint (area): _____.

When did symptoms appear? (date): _____ How?, (if known): _____

Is it getting progressively worse? __ yes __ no __ unknown ... The pain is: __ constant __ comes & goes

* * * Rate the severity of the pain: (circle #)



Type of pain: __ sharp __ dull __ throbbing __ numbness __ aching __ shooting __ burning

__ tingling __ cramping __ stiffness __ swelling __ other: _____

How often do you have the pain? (times a day/times a week, etc.) _____

Does it interfere with any of the following?: __ work __ sleep __ daily routine __ recreation

Activities/movements that are painful to perform: __ sitting __ standing __ walking __ bending __ lying down

In general would you say your overall health right now is: __ excellent __ very good __ good __ poor

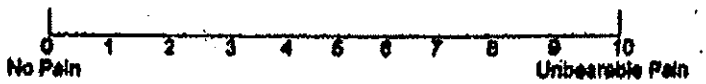
*Please continue **only if** there are additional complaints/areas...

 # 2 Complaint (area): _____

When did symptoms appear? (date): _____ How?, (if known): _____

Is it getting progressively worse? __ yes __ no __ unknown ... The pain is: __ constant __ comes & goes

* * * Rate the severity of the pain: (circle #)



Type of pain: __ sharp __ dull __ throbbing __ numbness __ aching __ shooting __ burning

__ tingling __ cramping __ stiffness __ swelling __ other: _____

How often do you have the pain? (times a week/times a day, etc.) _____

Does it interfere with any of the following?: __ work __ sleep __ daily routine __ recreation

Activities/movements that are painful to perform: __ sitting __ standing __ walking __ bending __ lying down

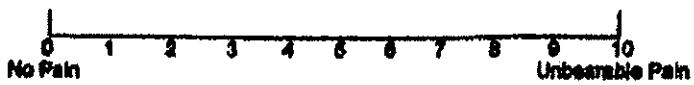
*Continue if there is additional...

 # 3 Complaint (area): _____

When did symptoms appear? (date): _____ How?, (if known): _____

Is it getting progressively worse? __ yes __ no __ unknown ... The pain is: __ constant __ comes & goes

* * * Rate the severity of the pain: (circle #)



Type of pain: __ sharp __ dull __ throbbing __ numbness __ aching __ shooting __ burning

__ tingling __ cramping __ stiffness __ swelling __ other: _____

How often do you have the pain? (times a day/times a week, etc.) _____

Does it interfere with any of the following?: __ work __ sleep __ daily routine __ recreation

Activities/movements that are painful to perform: __ sitting __ standing __ walking __ bending __ lying down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Family History

Please tell us if any close blood relative has/had the following medical conditions:
Mark all that all that apply.

_____Heart Disease _____Stroke _____Cancer

_____Diabetes _____Lung Disease _____Bone Disease

_____Rheumatoid Arthritis _____Multiple Sclerosis _____Autoimmune Disease

Father: Living_____ Deceased_____ Age_____

Mother: Living_____ Deceased_____ Age_____

Sisters: # Living_____ #Deceased_____ Age_____.

Brothers: # Living_____ # Deceased_____ Age_____

Assignments And Releases

Consent To Treat: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic testing procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). I understand there are risks involved with any medical services and have informed the doctor of any health related conditions that may affect my care.

Pregnancy Release: This is to certify to the best of my knowledge I am not pregnant and the doctor/associates/staff have my permission to perform diagnostic testing using X-ray equipment. I have been advised that x-rays may be hazardous to an unborn child.

Consent To Treat A Minor: I (we) being parent, guardian or custodian of the minor being _____Age_____, do hereby authorize Mack Chiropractic, assistants and or staff to administer chiropractic care/ treatment deemed necessary to the minor named above.

_____
Print Patients Name

_____Date_____
Signature of Patient/ Guardian

Assignments and Releases

Health Insurance/Medicare Assignment Of Benefits: I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, or billing agents for the processing of medical claims. I assign the benefits payable for medical services received directly to Dr. Patrick Mack/Mack Chiropractic and I acknowledge I am financially responsible for my deductable and coinsurance. Regarding commercial insurance policies, I certify that I and /or my dependents have insurance coverage with the insurance presented and I directly assign to Mack Chiropractic all insurance benefits that would be payable to me for services rendered. I understand that the insurance policy is a contract between the insured and the insurance company and that I am financially responsible for all charges whether or not the claim is paid by my insurance carrier. It is my responsibility to know the requirements pertaining to my policy. I authorize the use and disclosures of my medical records for the purpose of treatment, payment or healthcare operations. I authorize the use of my signature for all insurance submissions. In the event of out-of-network benefits, we ask that you bring or mail any checks, with a copy of any EOB's (Explanation of Benefits), to our office in a timely manner.

Notice Of privacy Practices: I_____(your name) acknowledge that I may request a complete copy of the Notice Of Privacy Practices, written in plain language, from Mack Chiropractic. It is also visibly displayed in the office waiting room. The notice provides in detail the uses and disclosures of my protected health information (PHI) that may be made by this practice, my individual rights and the practice's legal duties to protect my PHI. The practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all PHI that it maintains. I may request a copy at any time.

_____

Print Name

_____ Date _____

Signature of patient or legal representative

MACK CHIROPRACTIC
Contact Release Form

I understand that it is important that Mack Chiropractic be able to contact me by phone/email in regard to appointments, scheduling, and or closing.

I,_____, do hereby authorize Mack Chiropractic to contact me by phone and/or email to confirm/reschedule appointments, release results of diagnostic tests or to relay messages from Dr. Mack.

In my absence, I authorize the information to be released to the following:

- ○ **Spouse** Name_____
- ○ **Daughter** Name_____
- ○ **Son** Name_____
- ○ **Other** Name_____
- ○ **Answering Machine/Email - Please provide email address below.**

_____

This authorization will remain in effect until I revoke it in writing.

Signature_____ **Date**_____

Mack Chiropractic
269 Rt. 31 S. Suite 5
Washington NJ 07882

Billing/Patient Acknowledgement

The purpose of this form is for the patient to acknowledge responsibility of payment due when insurance is not covering, the reasons this may be so are:

- Maxed visits
- Insurance deeming treatment as not medically necessary
- Insurance deeming treatment as supportive/maintenance
- Insurance deeming treatment as preventative/wellness care
- The service, product or supply is not a covered benefit

The services, products and supplies generally being billed to the insurance:

- Spinal 1-2 Region ($56)
- Spinal 3-4 ($78)
- Spinal 5 ($99)
- Spinal Extra ($66)
- Manual Traction ($66)
- Mechanical Traction ($35)
- Electric Stimulation ($42)
- Neuromuscular Re-education ($74)
- Ultrasound ($27)
- X-RAYS ($80 - $240)
- DMB (durable medical equipment), orthotics, braces, portable tens units, etc. ($170 - $400)

I _____ **(Please print first & last name)**
Acknowledge that I have been told in advance by this office that the services, products and or supplies listed above may not be covered by my insurance plan due to the reasons stated above. I agree to pay for these non-covered services, products and or supplies at the time of service, when I am billed or when product or supply is provided.

I understand that insurance is not a guarantee of payment and I will be notified by the office if/when the insurance I have presented to the office is not covering. In this event the insurance will not be billed and I will be a cash patient meaning, **the office will not be submitting to my insurance.**

My complete understanding of this Acknowledgement is that in the event my insurance doesn't cover, I am responsible for $40.00 per visit, **which does not include X-RAY or DME.**

X _____ Date: _____
Patient or Legal Representative

_____
(Legal Rep.) Print first & last name Relationship