Patient Information

Name______________________________ Birth Date__________ Age____ Social Security # __________
First Middle Last

Address______________________ City__________________ State_____ Zip __________

Home Phone__________ Work Phone__________ Cell Phone__________ E-Mail __________

Insurance Company__________ Policy #__________ Employer__________ Occupation __________

Sex { M / F } Marital Status { S M D W } Spouse's Name__________ Spouse's Occupation__________

How did you hear about our office? __________ Have you had chiropractic care before? __________ When? __________

Area of Complaint(s) : ☐ Head ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Pelvis ☐ Hip ☐ Thigh ☐ Knee
☐ Lower Leg ☐ Ankle ☐ Foot ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand

Spine / Pain Radiation : ☐ Pain localized to spine ☐ Pain radiation to the head,elbow or knee ☐ Pain radiating below the elbow or knee

Briefly describe what you think caused your condition/symptoms : __________

Describe your current symptoms : __________

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Date symptoms appeared __________ **Duration of symptoms** ☐ 0 < 3 weeks ☐ >3 weeks- 6 weeks ☐ > 6 weeks

Are your symptoms improving? ☐ Improving ☐ About the same ☐ Getting worse ☐ Comes and goes

What aggravates your condition? ☐ Standing ☐ Sitting ☐ Walking ☐ Twisting ☐ Lying ☐ Lifting ☐ Other __________

What relieves your condition? ☐ Ice ☐ Heat ☐ Medication ☐ Rest ☐ Movement ☐ Other __________

Have you had these symptoms before? ☐ **No** ☐ **Yes** **(If yes, when? Was treatment performed ?)** Date __________

Describe treatment __________

Were any imaging studies or diagnostic tests performed regarding your current condition or past episodes? ☐ **No** ☐ **Yes** **(If yes, when? What tests were performed ?)** __________

Numeric Pain Rating Scale (NPRS) (no pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (unbearable pain)

Restrictions of activities of daily living (no limitations) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (totally disabled)

Physical work capacity as it relates to your current condition ☐ No work limitations ☐ Work limitations ☐ Unable to work __________

List all surgeries __________

List all non-prescription drugs __________

List all prescription drugs you are currently taking __________

Check here if you have a family history of : ☐ Arthritis ☐ Heart Disease ☐ Diabetes ☐ Cancer

Social habits ☐ Tobacco ☐ Alcohol ☐ Coffee

Exercise Activity ☐ No excercise program ☐ Light exercise ☐ Moderate exercise ☐ Strenuous exercise

If yes, describe exercise __________

Stress Level ☐ Little or no ☐ Minimal ☐ Moderate ☐ Greatly stressed

Physical work activity levels ☐ Sitting 50% or more ☐ Some manual labor ☐ Heavy lifting ☐ Repeated motions

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Please check any of the following that you may have had or have now: ☐ High blood pressure ☐ Asthma ☐ Gastric ulcers ☐ Joint pain ☐ Heart disease ☐ Bronchitis
☐ Gas/bloating ☐ Hiatal hernia ☐ Numbness ☐ Headaches ☐ Colitis/Spastic colon ☐ Jaw pain ☐ Heart murmurs ☐ Pulmonary disease ☐ Acid reflux
☐ Pneumonia ☐ Hepatitis A B C ☐ Sinus / Allergies ☐ Shoulder Pain ☐ Diabetes ☐ Emphysema ☐ Kidney problems ☐ Menstrual pains ☐ HIV +

Would you like us to send treatment notes to your family doctor? ☐ Yes ☐ No

If yes , doctor's name, address, phone __________

Patient Signature : __________ **Date** __________

Ronald E. Safko, D.C., F.A.C.O.

Diplomate American Board of Chiropractic Orthopedist
Fellow Academy of Chiropractic Orthopedists

Our Office Policy Regarding Insurance Assignment

Our office will be pleased to accept your insurance assignment as soon as your exact coverage is verified. We will file your claim forms and assist you in every way we can. ***However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.***

Office policy regarding insurance assignment:

1. *Once insurance coverage is verified, all copayments and non-covered services are the patient's responsibility and must be paid at the time of visit.*
2. *Your insurance should pay within 30 days. If your insurance has not paid within 90 days, you must pay the balance due and be reimbursed by your insurance company.*
3. *Your signature below acts as your agreement that Benefits are Assigned to Dr. Safko.*
4. *Our office does not guarantee that your insurance will pay. We will make every attempt, at the beginning of you health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied, you are responsible for the full amount of your bill.*
5. *Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.*

If you understand and agree with all of the above policies, please sign your name below and we will accept your insurance assignment when coverage is verified.

____________________________________ ________________________

Patient's Signature *Date*

I agree that payment by my insurance company will be paid directly to this office and will be credited to my account.

____________________________________ ________________________

Patient's Signature *Date*

Ronald E. Safko, D.C., F.A.C.O.

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

1. The Privacy Notice has been provided to me prior to my signing this Consent.

2. We reserve the right to change our privacy practices that are described in the Privacy Notice, in accordance with the applicable law.

3. We may use and/or disclose my PHI in order for us to treat and obtain payment for that treatment.

4. I understand that I have a right to request that Dr. Safko restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Dr. Safko is not required to agree to any restrictions that I have requested.

5. I understand that this Consent is valid for seven years.

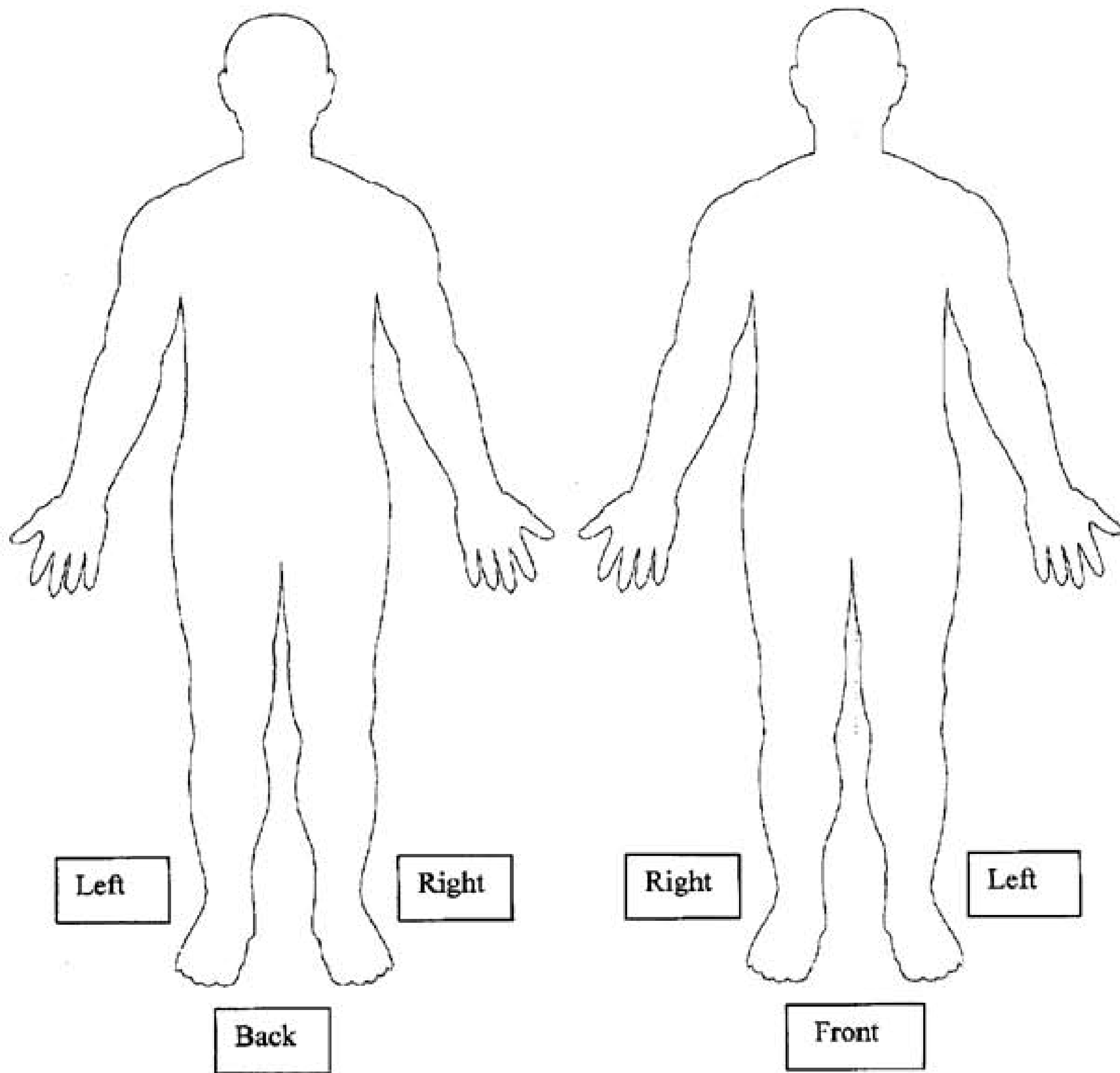
6. I understand that if I revoke this consent at any time, Dr. Safko has the right to refuse treatment.

7. I understand that if I do not sign this Consent Dr. Safko will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_________________________	_________________________
Name of Individual	Signature of Individual
_________________________	_________________________
Signature of legal Representative	Relationship

Date Signed ________ Witness: ____________________



Using the symbols listed below, mark on the two drawings above the areas on your body where you feel the described sensations:

Numbness	= = =	Hot Burning	x x x
Dull Ache	o o o	Sharp Stabbing	/ / /
Pins and Needles	+ + +	Other__________________	

Patient Signature: ______________________________________ Date: ____________