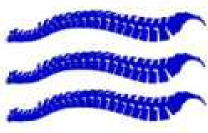


LAKE VIEW CHIROPRACTIC

1 PATIENT INFORMATION

Patient Name: ______________________

Last First MI

Date: ______________________

Social Security #: ______________________

Address: ______________________

City: ______________________

State: __________ Zip: __________

Sex: ☐ M ☐ F Birthdate: __________

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Partnered

Occupation: ______________________

Employer: ______________________

Employer's Address: ______________________

City: ______________________

State: __________ Zip: __________

Employer's Phone: ______________________

Spouse's Name: ______________________

Spouse's Occupation: ______________________

Spouse's Employer: ______________________

Number of Children: ______________________

Whom may we thank for referring you?

____

2 INSURANCE INFORMATION

Who is responsible for this account?

____

Relationship to Patient?: ______________________

Insurance Company: ______________________

Member/Group #: ______________________

Additonal health insurance? ☐ Yes ☐ No

Subscriber's Name: ______________________

Birthdate: __________ SS#: __________

Relationship to Patient?: ______________________

Insurance Company: ______________________

Member/Group #: ______________________

I hereby instruct the above named Insurance Company to pay by check made out to **Martin J. LaBuda, DC, PC** for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indeptedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

____

Signature of Patient, Parent, Guardian or Representative

__________ __________

Date Relationship to Patient

3 CONTACT INFORMATION

Cell Phone: ______________________

Home Phone: ______________________

E-Mail: ______________________

May we contact you by E-Mail? ☐ Yes ☐ No

Emergency Contact: ______________________

Phone #: ______________________

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Type of Accident?: ☐ Auto ☐ Work ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer/Work Comp ☐ Other

Attorney's Name (if applicable):

____

5 PATIENT CONDITION

Reason for Visit: ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Have you had this in the past?: ☐ Yes ☐ No

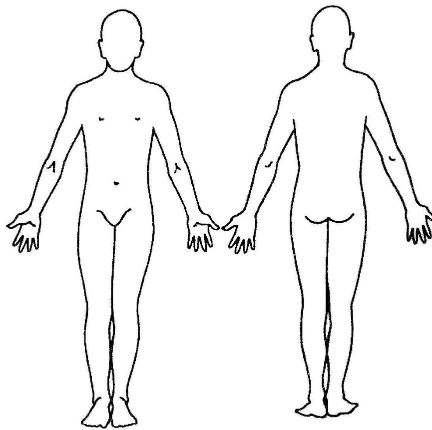
Is the pain ☐ Constant ☐ Comes & Goes

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What aggravates your pain? ____________________

Does anything relieve the pain? ____________________

Mark the areas on this body where you feel discomfort.



Please mark an "X" on the pain scale below that best describes the level of your pain.

No Pain |————————————————| Worst Pain Imaginable

6 HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other ☐ None

Name of other doctor(s) who have treated you for this condition ____________________

What is your exercise level? ☐ None ☐ Moderate ☐ Daily ☐ Heavy

What is your work activity? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

What are your habits? ☐ Smoking ____ packs/ day ☐ Alcohol ____ drinks/week
☐ Caffeine Drinks ____ cups/day ☐ High Stress Level

Medications/Supplements? ____________________

Supplements? ____________________

Allergies? ____________________

Surgeries/Hospitilazations? ____________________

Date: ____________ Signature: ____________________

7 OTHER SYMPTOMS (please check (x) all *PRESENT* symptoms)

General
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight loss or gain
- ☐ Allergies
- ☐ Bleeding Problem
- ☐ Anemia
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid Disease/Goiter
- ☐ Alcoholism
- ☐ Drug Abuse

Eye, Ear, Nose, and Throat
- ☐ Poor Vision
- ☐ Pain in Eye(s)
- ☐ Deafness/Difficulty Hearing
- ☐ Nosebleeds
- ☐ Nose Problems
- ☐ Sinus Trouble
- ☐ Dental Problems
- ☐ Hoarseness
- ☐ Tonsillectomy

Respiratory
- ☐ Difficulty Breathing
- ☐ Chronic Cough
- ☐ Spitting Phlegm
- ☐ Spitting Blood
- ☐ Wheezing/Asthma
- ☐ Pneumonia
- ☐ Tuberculosis

Skin
- ☐ Itching
- ☐ Bruising Easily
- ☐ Change in mole(s)
- ☐ Skin Cancer

Cardiovascular
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Pain over Heart
- ☐ Previous Heart Trouble
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Rheumatic Fever
- ☐ Stroke

Gastrointestinal
- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Difficulty Swallowing
- ☐ Belching or Gas
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Pain over Abdomen
- ☐ Ulcer
- ☐ Black or Bloody Stools
- ☐ Liver Problems
- ☐ Gall Bladdar Problems
- ☐ Yellowing of Skin (Jaundice)
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Appendicitis

Genitourinary
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Disease
- ☐ Urinary Infection
- ☐ Inability to Control Urination
- ☐ Difficulty Starting Urine Flow
- ☐ Get up ____ times to Urinate
- ☐ Breast Lump or Pain
- ☐ Venereal Infection

Men Only
- ☐ Testicular Swelling/Pain
- ☐ Prostate Problems

Women Only
- ☐ Menstrual Pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle ____ Days
- ☐ Hysterectomy
- ☐ Tumors/Cancer of __________
- ☐
- ☐ Menopause
- ☐ Currently Pregnant

Neurologic
- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Numbness/Tingling
- ☐ Mental Disorder

Musculoskeletal
- ☐ Neck Stiffness/Pain
- ☐ Pain Between Shoulders
- ☐ Low Back Pain
- ☐ Swollen Joints
- ☐ Muscle Aches/Soreness
- ☐ Spinal Curvature
- ☐ Arthritis
- ☐ Shoulder Pain
- ☐ Arm/Elbow Pain
- ☐ Wrist/Hand Pain
- ☐ Hip Pain
- ☐ Leg/Knee Pain
- ☐ Ankle/Foot Pain

Family History
DO NOT INCLUDE YOURSELF
- ☐ Diabetes
- ☐ Thyroid Disease/Goiter
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer
- ☐ Muscle, Bone, or Nerve Disease
- ☐ Other ______________________

Date: ____________________ Signature: ______________________________________

8 INFORMED CONSENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by Martin J. LaBuda, DC and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for Martin J. LaBuda, DC.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

I also understand that Paul T. Hackett D.C. PC. and Martin J. LaBuda D.C. PC. are two separate corporations doing business as **Lake View Chiropractic**.

Signature of Patient　　　　　　Date

Signature of Patient's Representative　　　　　　Date

9 FINANCIAL AGREEMENT

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover Chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for Chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner.

PAYMENT ARRANGEMENTS

We require that you pay 100% of your charges on a per visit basis. If your balance is not paid per visit, we require that your balance be paid by the 1st day of each month and any unpaid balance will be considered past due on the 1st day of the following month. An interest charge of 6% may be applied to your unpaid balance. If this arrangement is inconvenient for you, please speak with us as payment plans are available.

VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately, will be personally responsible for payment, regardless of your insurance coverage.

I have read and agree to the above.

Signature of Patient　　　　　　Date

10 NOTICE OF PRIVACY PRACTICES

I hereby give my consent to MARTIN J. LABUDA, DC, PC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available by US Mail.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

______________________________ ______________

Signature of Patient Date

If you are not the patient, please specify your relationship to the patient.

____