Patient Check in:

Patient: ______________________________
Last Mid First

Address: ______________________________
Street Apt/Unit No.

____
City State Zip

Phone: (H) ______________ (C) ______________

Email: ______________________________

How or from whom did you hear about us?

____

Date of Birth: ______________
(mm/dd/yyyy)

SS# ______________

Language ______________

Ethnicity ______________

Race ______________

Check all that apply:

☐ Minor ☐ Female ☐ Male

☐ Married ☐ Single ☐ Student

Primary Ins. Circle: PPO HMO Other Unknown

Company Name: ______________

Plan Name: ______________

Claims Address: ______________

City: ______________ State: ________ Zip: ________

Phone: ______________ Fax: ______________

Policy # ______________ Group # ______________

Insured Name: ______________

Address: ______________

City: ______________ State: ________ Zip: ________

Phone: ______________ DOB: ________ Sex: ________

Insured Employer: ______________

Claims Address: ______________

City: ______________ State: ________ Zip: ________

Phone: ______________ Fax: ______________

Patient Relationship to Insured: ______________

Policy Holder: ______________

Address: ______________

City: ______________ State: ________ Zip: ________

Phone: ______________

Provide the following information if guarantor is different than patient

Guarantor's Last Name: ______________

First Name: ______________ Middle: ______________

Address ______________

City ______________ State ________ Zip ________

Phone: ______________

SS# ______________

Patient Relationship to Guarantor:

____

Provide the following information if visit is an Accident or Worker's Compensation Claim

Employer Name ______________

Address: ______________

City: ______________ State: ________ Zip: ________

Phone: ______________

Fax: ______________

Email: ______________

Contact: ______________

Auto Accident: ______________ On the job? ________ Date of Injury: ______________

Authorization # ______________ Referring Doctor: ______________

Adjuster ______________

Please List:

Drug allergies ______________ Current medications ______________

I authorize the Attending Physician to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand I am responsible for all medical fees during my treatment with the attending Physician.

If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to the attending Physician.

Print Name: ______________ Signature: ______________ Date: ______________

Symptom(s):

Date of onset:____________ Causes of symptom(s): ____

Where are your pain(s)/ symptom(s):____

Do you suffer from any of the follow:

- ☐ Headaches
- ☐ Concentration
- ☐ Jaw pain
- ☐ Wake you from sleeping
- ☐ Caused you to miss work, school, or activities
- ☐ Indigestion/ heartburn
- ☐ Nausea or vomiting
- ☐ Blurred or doubled vision
- ☐ Ringing in ears

Frequency of symptoms(s):

☐Constantly (76-100%) ☐ Frequently (51-75%)
☐Occasionally (28-50%) ☐ Intermittently (0-25%)

Nature of symptom(s):

☐Burning ☐Shooting ☐Tingling
☐Aching ☐Stabbing ☐Throbbing
☐Numb ☐Sharp ☐Tight

Pain Intensity:

Using a scale of 1 to 10 rate your pain.
(10 being worst pain and 1 being no pain)

Current Pain _____ Average Pain _____ Worst Pain _____

What makes the symptoms worse?

☐Lifting ☐Driving ☐Sleeping
☐Reading ☐Recreation ☐Social life
☐Headaches ☐Walking ☐Traveling
☐Concentrating ☐Sitting ☐Personal care
☐Work ☐Standing

What makes the symptoms better?

☐Rest
☐Stretching
☐Ice
☐Heat

Laying on:
☐ Back
☐ Stomach
☐ Left side
☐ Right side

Medical History:

List all Surgeries: ____________________________ Traumas/ Fractures: ____________________________

Current Medications: ____________________________ Allergies: ____________________________

Pregnant: ☐Yes ☐No

Alcohol: ☐Yes ☐No If yes, how much per week? ______________

Smoking: ☐Yes ☐No If yes, how many packs per week? ______________

Exercise: How often per week?______________________________

Anything else we should know about?____

Put (P) for Patient, (M) Mother, (F) Father, (S) Sibling

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Stroke
☐ Thyroid ☐ Asthma ☐ Heart Attack ☐ Seizures/Convulsions
☐ Other ______________

Chiropractic has one of the safest records of all forms of healthcare. Serious complications a very rare but they are possible. Our duty is to inform you of potential side effects or complications that are rarely associated with any form of treatment, including chiropractic care. Soreness or muscle tightness are the most common negative but are usually brief and are only brief reactions to treatment. Possible adverse of adjustments include reactive muscle spasm, injury to disc, pressure on nerve tissue, fractures in weakened bones, and injury to arteries resulting stroke. Some studies suggest the chiropractic adjustments are up to 1,000 times more likely to cause damage than some "routine" neck and back surgeries (information can be found in the June, 1999 issue of New England Journal of Medicine).

Signature:__________________________ Date:______________

Assign of Proceeds and Right to Collect:

Insurance is a vehicle that assists you, the patient, on covering the cost of chiropractic care. It is a contract between you and the insurance company. We accept your insurance as partial payment. The patient (a.k.a. "me", "I", "my", "you" etc.) is ultimately responsible for services provided at this office. I herby assign, transfer and set over to Dr. Ryan Jones all of my rights, title and interest to my medical reimbursement benefits under any insurance policy. I authorize the release of any information needed to determine and/or collect these benefits. This authorization shall remain valid until written notice is given revoking said authorization. I guarantee that all patient information is correct to the best of my knowledge.

Under the event that our office is not under any contract with your current insurance carrier and the bill is not paid within 60 days of billing the obligation of payment of all fees incurred at Dr. Ryan Jones' (Align Your Health Chiropractic PLLC) reverts back to the patient. Our office policy requires that the patient pay their percentage of the total bill, including any co-payment and/or deductible, at the time service is rendered; the percentage depends on your carrier.

In summary, the financial obligation for all treatment received is the patient's responsibility, regardless of insurance coverage, attorney liens, 3rd parties, settlements etc.

Patient Understanding and Acceptance of All Office Policies:

By signing below, I acknowledge that I fully understand and agree to follow all policies and procedures. I accept Chiropractic Care and treatment under the policies listed herein.

Signature:_____________________________ Date:_______________