CONFIDENTIAL PATIENT INFORMATION

CLEARVIEW CHIROPRACTIC WELLNESS CENTER
Casey Titus, D.C.
1 Ocean Boulevard #104
Southern Shores, NC 27949
Ph: (252) 261-3100 Fax: (252) 261-3240

Patient Demographics

Last Name:	First Name:	MI:
DOB: / /	Gender: M F	SSN: - -
Marital Status:	Reason For Visit : Neck, Back, Extremities	Referred By:
Preferred Language:	Race:	Ethnicity:
Address Line 1:	Address Line 2:	
City:	State:	Zip Code:
Home Phone: ( ) -	Work Phone: ( ) -	Ext:
Cell Phone: ( ) -	Fax: ( ) -	
Email:		Preferred Phone:

Employment Information

Employer Name:	Employer Phone: ( ) -	
Address Line 1:	Occupation:	
City:	State:	Zip Code:

Emergency Contact

Contact Name:	Relationship to Patient:	
Address Line 1:	Address Line 2:	
City:	State:	Zip Code:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -

Next of Kin

Contact Name:	Relationship to Patient:	
Address Line 1:	Address Line 2:	
City:	State:	Zip Code:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -

I certify the above information is true and correct to the best of my knowledge.

Sign _____ **Date** _____

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Review of Systems

List all prescription medications and other supplements you take as well as the dose.

_____

_____

List anything you are **allergic** to: _____

Yes No Have you smoked? How often?_____
Start date: _____ End date: _____
Yes No Have you chew tobacco? How often?_____
Start date:_____ End date:_____
Yes No Do you ever have skin, hair, or nail problems? _____
Yes No Have you recently had any rashes/ blistering? _____
Yes No Do you ever have mouth or throat problems? _____
Yes No Do you ever have nose or sinus problems? _____
Yes No Do you have hearing or other ear problems? _____
Yes No Do you have visual problems? _____
Yes No Do you have recurring headaches/ migraines? _____
Yes No Do you have chest, lung, or breathing problems? _____
Yes No Do you ever have recurring infections? _____
Yes No Do you ever have heart or blood vessel problems? _____
Yes No Do you have high cholesterol or blood pressure? _____
Yes No Have you ever suffered a stroke or heart attack? _____
Yes No Do you ever have blood or lymph node problems? _____
Yes No Do you ever have digestive problems? _____
Yes No Do you ever have urinary or bowel problems/ infections? _____
Yes No Do you have any nervous system diseases or mental health problems? _____
Yes No Have you ever suffered from depression? _____
Yes No Do you ever have hormone or gland problems? _____
Yes No Are you Diabetic? _____
Yes No Do you ever have numbness or tingling? _____
Yes No Do you ever have immunity problems? _____
Yes No Do you recently feel weakness or fatigue more than in the past? _____
Yes No Do you have muscle, tendon, or ligament problems? _____
Yes No Do you have any bone or joint diseases like osteoporosis or arthritis? _____
Yes No Have you ever been diagnosed with cancer? _____
Yes No Does your pain wake you up at night? _____
Yes No Have you had any recent weight gain or loss? _____
Yes No Do you ever have sores that are slow to heal? _____

Females Date of your last menstrual period: _____
Yes No Do you take birth control? _____
Yes No Is there a chance that you are currently pregnant? _____

I certify this health information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____
Patient (parent or guardian) Signature Date
**Required if any person other than the patient being treated is preparing this form. Signature indicates consent to care of a minor child.*

Brief Pain Inventory (Short Form)

Date: _____

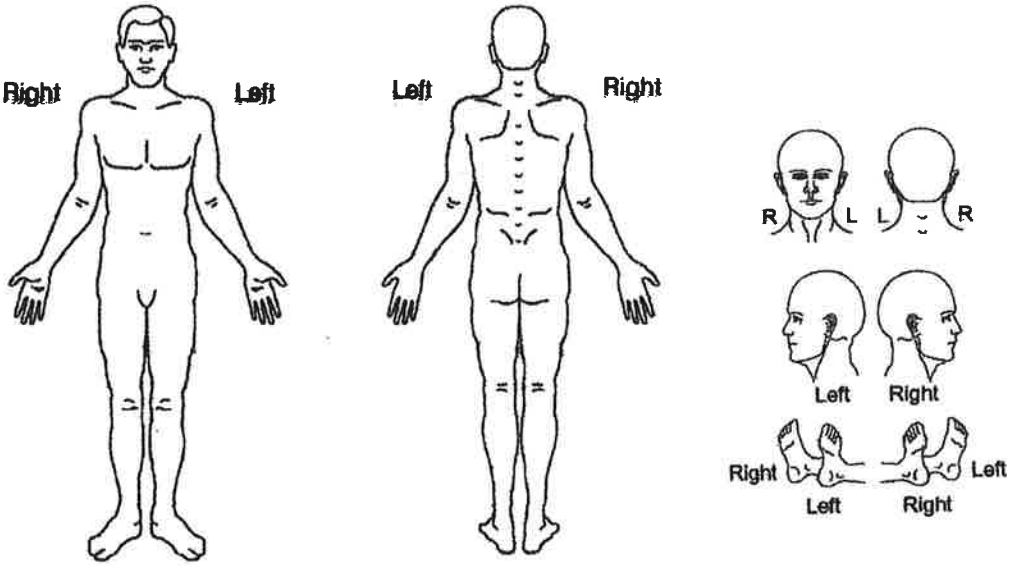
Name: _____

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

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Insurance

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (Please initial)

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (Please initial)

C_____ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment and will pay when services rendered.

Insurance Company_____ Policy ID_____

Insurance Coverage

Welcome to Clearview Chiropractic Clinic. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and / or deductable. For example: if you have a deductable of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

Missed Appointments

It is the policy of Clearview Chiropractic Clinic to assess a **$25** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in assessment of a fee, but you will be charged for any additional missed visits. **Any future scheduled appointments will be canceled.** This clinic provides care for many individuals and miss visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____
Signature Date

_____ _____
Parent or guardian signature Date

**Required if any person other than the patient being treated is preparing this form. Signature indicates consent to care of a minor child.*