PATIENT INFORMATION FORM

New Patient _____ Previous Patient _____ Patient Code _____ Date_____

NAME: FIRST_____ M.I._____LAST_____

Home Address_____ City _____State _____Zip_____

Home Phone _____ Cell Phone _____

Work Phone _____ E-Mail address _____

Date of Birth ____/____ /_____ Age_____ Marital Status (S M W D) Male _____Female_____

Social Security # _____/_____ /_____ Medicare # _____/_____ /_____

Driver's License #_____ Referred by_____

Employer _____ Job Title_____

Employer Address, City, State_____

Spouse's Name_____ Spouses date of birth _____/_____ /_____

Employer of Spouse_____ Spouse's work phone _____

Address_____ City _____State _____Zip_____

Job Title of Spouse _____ Spouse's Cell Phone _____

Person responsible for this account _____

Are you or do you think you might be pregnant? 1) Yes 2) No

Cause of complaint (Circle): 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness
5) Congenital 6) Unknown

Date of Incident _____

INSURANCE INFORMATION:

Present Insurance card to the front desk to be photocopied

Payment is due at the time of service. In the event I am covered by any insurance policy(ies), I hereby assigned my right to obtain payment directly to this office. I authorize payment received from the insurance company(ies) to be credited to my account upon receipt. I understand and agree I am personally liable and responsible for all charges rendered on my account. I also understand and agree if no payments are made on my account for sixty (60) days, I may be charged and I am liable for a monthly late fee up to thirty-five ($35.00) dollars per month until paid. I understand if no payment is made or I suspend or terminate my care, the full amount of all fees and costs are immediately due and payable. In the event no payment is made after sixty (60) days of my last service of termination of service, I shall be in default of my agreement to pay. In that event, I understand I will be liable for and agree to pay all attorney fees and costs if turned over to an attorney for collections.

Patient's Signature _____ Date: _____

PATIENT HEALTH HISTORY

NAME: _____ **Family Physician:** _____

1) FAMILY HISTORY: (circle as many as apply)

MOTHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased - Age at death: _____

FATHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased - Age at death: _____

SIBLINGS: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

2) SOCIAL HISTORY:

MARITAL STATUS:	1) Single	2) Married	3) Divorced	4) Widowed				
NUMBER OF CHILDREN:	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(None)
DO YOU:	1) Exercise regularly	2) Eat a balanced diet	3) Obtain sufficient rest					
DO YOU SMOKE?	1) No	2) Less than 1	3) 1-2	4) 2-3	5) 3-4	6) More than 5	(packs / day)	
DO YOU DRINK COFFEE /TEA?	1) No	2) Occasionally	3) 1-2	4) 2-3	5) 3-4	6) More than 5	(cups / day)	
DO YOU DRINK ALCOHOL?	1) No	2) Occasionally	3) 1-2	4) 2-3	5) 3-4	6) More than 5	(drinks / day)	

3) MEDICAL HISTORY:

CHILDHOOD ILLNESSES: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes

LIST ANY SERIOUS CHILDHOOD ILLNESSES NOT RECORDED ABOVE.

_____ Age: [ ]
_____ Age: [ ]
_____ Age: [ ]
_____ Age: [ ]

LIST ANY BIRTH DEFECTS: _____

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason, and dates.

_____ M/D/Y _____/_____/_____
_____ M/D/Y _____/_____/_____
_____ M/D/Y _____/_____/_____
_____ M/D/Y _____/_____/_____

ADULT ILLNESSES/INJURIES: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

_____ M/D/Y _____/_____/_____
_____ M/D/Y _____/_____/_____
_____ M/D/Y _____/_____/_____
_____ M/D/Y _____/_____/_____

4) MEDICATIONS:

List all medications that you are currently taking or have taken on a regular basis in the last 6 months (include home remedies).

A) _____ B) _____

C) _____ D) _____

MEDICATIONS TO WHICH YOU ARE ALLERGIC:

A) _____ B) _____

C) _____ D) _____

SYMPTOM SURVEY

12) GENERAL SYMPTOMS: (Circle as many as apply)

A) Nervousness B) Irritability C) Fatigue D) Depression

E) Loss of Sleep F) Tension G) PMS H) Jaw Pain

13) HEAD: (Circle as many as apply)

A) Headache - 1) Mild 2) Moderate 3) Severe

How often: (1 2 3 4 5 6) Per (Day/Wk./Mo.)

Are they: 1) Sharp 2) Dull

Are they: 1) Constant 2) Intermittent

Where located: 1) Back of head 2) Forehead

3) Temples 4) Rt. Side

5) Lft. Side 6) Behind eyes

B) Light headed C) Memory loss D) Fainting

E) Blurred vision F) Double vision G) Sensitivity to light

H) Loss of balance I) Hearing loss J) Ringing in ears

14) NECK: (Circle as amany as apply)

A) Pain - 1) Left side 2) Right Side 3) Both

Pain Level - 1) Mild 2) Moderate 3) Severe

Pain increased by: 1) Forward movement

2) Backward movement

3) Rotate head lft. 4) Rotate head rt.

5) Bend neck left 6) Bend neck right

B) Stiffness C) Muscle Spasm D) Grinding/Grating sounds

15) SHOULDERS: (Circle as many as apply)

A) Pain in Joint - 1) Left 2) Right 3) Both

B) Pain Across Shoulder - 1) Left 2) Right 3) Both

C) Limitation of Movement - 1) Left 2) Right 3) Both

D) Tension - 1) Left 2) Right 3) Both

16) ARMS: (Circle as many as apply)

A) Pain in Upper Arm - 1) Left 2) Right 3) Both

B) Pain in Elbow - 1) Left 2) Right 3) Both

C) Pain in Forearm - 1) Left 2) Right 3) Both

D) Pins & Needles (Arm) - 1) Left 2) Right 3) Both

E) Pins & Needles (Forearm) - 1) Left 2) Right 3) Both

F) Numbness in Arm - 1) Left 2) Right 3) Both

G) Numbness in Forearm - 1) Left 2) Right 3) Both

17) HANDS: (Circle as many as apply)

A) Pain in Wrist - 1) Left 2) Right 3) Both

B) Pain in Hand - 1) Left 2) Right 3) Both

C) Pins & Needles (Hand) - 1) Left 2) Right 3) Both

D) Numbness (Hand) - 1) Left 2) Right 3) Both

18) MIDBACK: (Circle as many as apply)

A) Pain - 1) Left 2) Right 3) Both

Pain Level - 1) Mild 2) Moderate 3) Severe

Pain Type - 1) Sharp/Stabbing 2) Dull Ache

B) Muscle Spasm - 1) Left 2) Right 3) Both

19) CHEST: (Circle as many as apply)

A) Deep Chest Pain - 1) Left 2) Right 3) Both

Pain Level - 1) Mild 2) Moderate 3) Severe

B) Pain around Ribs - 1) Left 2) Right 3) Both

C) Shortness of Breath

D) Irregular Heartbeat

20) ABDOMINAL SYMPTOMS: (Circle as many as apply)

A) Pain - 1) Mild 2) Moderate 3) Severe

B) Nervous Stomach C) Nausea D) Gas E) Constipation

F) Diarrhea G) Heartburn H) Indigestion I) Loss of Appetite

21) LOWBACK: (Circle as many as apply)

A) Upper Lumbar Pain - 1) Left 2) Right 3) Both *

B) Lower Lumbar Pain - 1) Left 2) Right 3) Both *

C) Sacro-Iliac Pain - 1) Left 2) Right 3) Both *

D) Muscle Spasm - 1) Left 2) Right 3) Both

* Lowback Pain Level - 1) Mild 2) Moderate 3) Severe

22) HIPS AND LEGS: (Circle as many as apply)

A) Pain in Buttocks - 1) Left 2) Right 3) Both

Pain Level - 1) Mild 2) Moderate 3) Severe

B) Pain in Hip Joint - 1) Left 2) Right 3) Both

Pain Level - 1) Mild 2) Moderate 3) Severe

C) Pain Down Leg - 1) Left 2) Right 3) Both

Location - 1) Front 2) Back 3) Side

Pain Radiates to - 1) Knee 2) Calf 3) Foot

D) Numbness Down Leg - 1) Left 2) Right 3) Both

Location - 1) Front 2) Back 3) Side

E) Pins & Needles (Leg) - 1) Left 2) Right 3) Both

Location - 1) Front 2) Back 3) Side

F) Knee Pain - 1) Left 2) Right 3) Both

G) Leg Cramps - 1) Left 2) Right 3) Both

23) FEET: (Circle as many as apply)

A) Ankle Pain - 1) Left 2) Right 3) Both

B) Swollen Ankle - 1) Left 2) Right 3) Both

C) Foot Pain - 1) Left 2) Right 3) Both

D) Numbness of Feet - 1) Left 2) Right 3) Both

E) Swollen Feet - 1) Left 2) Right 3) Both

F) Cramps - 1) Left 2) Right 3) Both

RONALD K WASSENAR D.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of Dr. Ronald K
(Printed Patient Name)
Wassenar's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

10526 Cermak Rd., Suite 104 Westchester IL 60154-5240
Telephone: 708-562-9200 Fax: 708-562-9207

Wassenar Chiropractic
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. This practice accepts cash, and personal checks. There is a service charge in the amount of thirty-five ($35.00) for returned checks. Any outstanding balance greater than thirty (30) days past due is subject to a thirty-five ($35.00) account service fee.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments. We realize that people have financial difficulty. Therefore, we may help you set up a payment schedule.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

We do not bill secondary insurance companies.

If you need assistance or have questions, please contact the office between 10:00 a.m. and 4:30 p.m., Monday through Friday at 708-562-9200.

REFUNDS:

Overpayments will be refunded upon written request to the responsible party within 30 days.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Wassenar Chiropractic Financial Policy. I agree to assign insurance benefits to Wassenar Chiropractic. I also agree that if it become necessary to forward my account to an attorney or collection agency, in addition to the amount owed, I also will be responsible for the fees charged by the attorney or collection agency for costs of collections.

Signature of insured or Authorized representative: _____

Date: _____