GATEWAY CHIROPRACTIC, P.C.
14930 LaPlaisance Rd #116 Monroe, MI 48161
(734) 242-4422

Date: _____

Name(last) _____ (first) _____ (MI) _____

Address_____
(Street) (City) (State) (Zip)
Home Phone #_____ **Cell #** _____

Birth Date_____ **Email** _____

Marital Status: S M OTHER **SS#**_____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

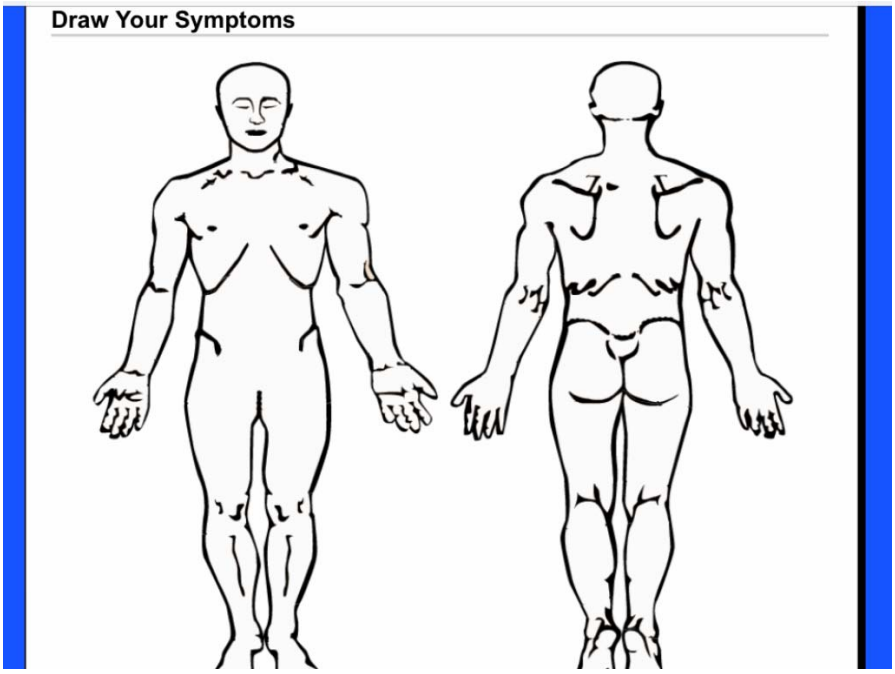
Health INS: BCBS PPOM AETNA PARAMOUNT NONE OTHER_____

Policy Holder: _____ Policy Holders DOB: _____

Enrollee ID# _____ Group #_____

What is your chief complaint for your visit today?

_____



What symptoms are you having? Check all that apply.

Aching __	Numbness__	Stabbing __	Diffuse __	Radiating __	Tightness __
Dull __	Sharp __	Tingling __	Cramping__	Pulsating __	Throbbing__
Excruciating__	Shooting __	Weakness__	Burning __	Pounding __	Stabbing __

Rate the severity of your pain at its least and greatest times by checking two boxes on scale.

0 1 2 3 4 5 6 7 8 9 10

When did this happen? _____
How did this happen? _____

How often do you feel the symptoms?
Less than 10% 25% 50% 75% 100%

What makes symptoms better? _____
What makes symptoms worse? _____

Have you had previous Chiropractic care? YES or NO If YES, when was last adjustment ? _____

What other treatments have you done for this symptom?
Chiropractic _____ Pain Medication_____ Exercise_____
Ice _____ Heat _____Rest _____

How is this affecting your daily life? What activities are you unable to do?
_____
_____

Height_____Weight_____ Do you use: **Alcohol** **Tobacco** **Caffeine**

Any previous illnesses/injuries? Please List
_____
_____

List all Surgeries:
Type_____ When_____
Type_____ When_____
Type_____ When_____

Current medications?
Name_____For what_____How Long_____
Name_____For what_____How Long_____
Name_____For what_____How Long_____
Name_____For what_____How Long_____

Please list any allergies :_____
.
Any family history of back/neck problems? _____

Do you have any vomiting, nausea, fever, chills, or any unexplained weight loss or weight gain? _____

Have you ever broken ribs or had any serious spinal injuries? _____ If yes, please explain to doctor upon examination

Past and Present Conditions
Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

Headaches_____	Dizziness _____	Weak Immune system_____
Neck Pain ____	Pins/Needles in arms/hands ____	TMJ _____
Low Back Pain _____	Pain in legs and feet _____	Pain in joints _____
Diabetic problems _____	Heart Problems _____	High Blood Pressure _____
Breathing problems _____	Asthma _____	
Sinus problems _____	Allergies _____	
Eye problems _____	Ear problems _____	
Indigestion _____	Stomach problems _____	
Skin problems _____	Gall Bladder problems _____	Thyroid problems _____
Constipation _____	Bladder problems _____	Bowel problems _____
Liver problems _____	Kidney problems _____	Menstrual problems _____
Weight problems _____	Fatigue _____	Sleeping problems _____

Whom can we thank for referring you to our office? _____

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference. I consent to the customary examinations, tests and procedures performed at Gateway Chiropractic, P.C. and to routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others.

*_____ INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original *_____ INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

*_____ INITIALS

MISSED APPOINTMENT POLICY

Gateway Chiropractic, P.C. reserves the right to bill any patient $15 for a missed appointment with no advance notice of cancellation or reschedule. *_____ INITIALS

SIGNATURE_____ DATE_____.

Patient Financial Responsibility

Payment is Expected at Time of Service
For all patients, payment of insurance co-pays and services not covered by insurance are to be paid for at the time the service is rendered. We will try to get insurance benefits as a courtesy for you. What we receive from the insurance company is a quote of benefits, not a guarantee. You are responsible for any balances not covered by your insurance, including rejected claims. While every effort will be made to submit claims in accordance with insurance requirements for payment, in the event of a dispute or rejection, you as the insured or guarantor are responsible for payment. The insurance contract is between you and your insurance provider, not between the insurance company and Gateway Chiropractic.

Insurance claims not paid within 90 days after the original date of service will become the responsibility of the patient/insured.

_____ _____
Signature Date

PAYMENT RESPONSIBILITY FOR DIVORCED/SEPARATED PARENTS
The person who brought the child in for services is responsible for payment. This office cannot be responsible for collecting from any other individual.

I acknowledge that I have read and understood this payment policy.

_____ _____
Signature Date

Consent for Purposes of Treatment and Healthcare Operations

I acknowledge that Gateway Family Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review Gateway Family Chiropractic's Notice of Privacy prior to signing this document. Gateway Family Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Gateway Family Chiropractic. The Notice of Privacy Practices for Gateway Family Chiropractic is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and Gateway Family Chiropractic's duties with respect to my protected health information.

Gateway Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the offices and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative