New Patient Paperwork

3715 Patriot Way #139
Wilmington, North Carolina 28412

Welcome to our clinic! We specialize in assisting our patients to achieve their highest level of health through our rehabilitative programs. Our approach is very unique and advanced from other rehab programs. This allows our patients to attain far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if we can accept your case. Please feel free to ask any questions if you need assistance. By signing below you are allowing us to treat you and file with your health insurance company. Any unpaid portion of the filing is the responsibility of you, the patient. We look forward to serving you!

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Patient Information

Patient Name:________________________________ Date of Birth:__________________________________

Gender:______________________ Age:______

Height:__________ Weight:____________

Address:____

Home Phone:_____________________________ Cell Phone:________________________________

Email:____

Employer/School:____

Occupation:____

In Case of Emergency

Name:______________________________ Relationship:____________________________

Home Phone:_________________________ Cell Phone:____________________________

Referring Physician

Name:_______________________________

Phone:______________________________ Fax:_________________________________

Address:____

Primary Care Physician

Name:______________________________

Phone:______________________________ Fax:_________________________________

Address:____

Accident Information

Is this condition due to an accident? ___________________________

Date of Injury:_________________________________

Type of Accident: Auto_____ Work______ Home______ Other______

Have you made a report of your accident? Yes______ No_______

Attorney Name:____________________________________

Attorney Address:____

Attorney Phone:_________________________

Purpose of your Visit Questionnaire

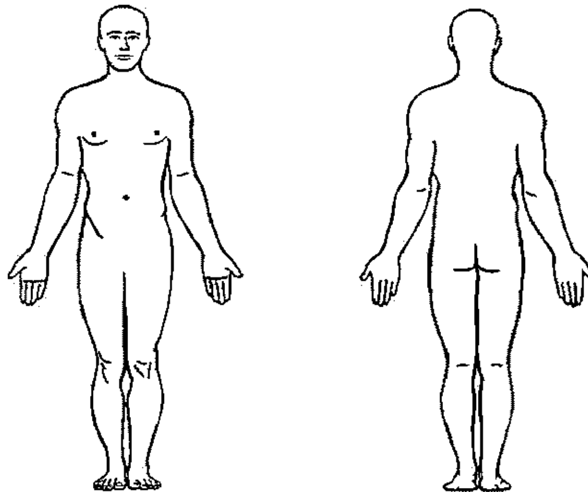
Chief Complaint(s):____

Onset Date of Symptoms:____________________

Please mark your pain on the body shown below. Use the following markings:

✓ = Sharp Pain ◯ = Dull Pain /// = Numbness +++ = Tingling

Draw arrows (⇩) for radiating pain



Please rate your pain (0 = No pain; 10 = Severe pain that would send you top the hospital):

Current Pain: _____

Worst Pain in past 24 hours: _____

Best Pain in past 24 hours: _____

List any diagnostic tests (X-Rays, MRI's, etc) & the results, if any: ___________________________

____

Medical History

Do you have allergies? If so, please list:____

____

Do you have or have you ever had any of the following? *Please mark all that apply.*

- ☐ AIDS/HIV
- ☐ Alzheimer's
- ☐ Anaphlyaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives/Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Care
- ☐ Renal Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling in Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

If you checked ***yes*** to any of the above, please explain. ______________________________

____

Are there any conditions or diseases not listed that you have or have had? Please list. __________

____

Have you had any falls in the past year? Yes______ No______

If yes, when and how many? ____

List any and all medications, vitamins, and herbs that you take as well as dosage and frequency: ____

____

List all surgeries, significant injuries and illnesses: ________________________________

____

Health Lifestyle

Do you exercise? Yes_______ No________

If yes, per week, how often? 1X______ 2X______3X______4X______5 or more_______

Do you smoke? Yes_______ No_______

If yes, how many per week?_________________

Do you drink alcohol? Yes_______ No_______

If yes, how much per week?______________

Do you drink coffee? Yes_______ No________

If yes, how many cups per day?_______________

Work Activity: Sitting_______ Standing_________ Light Labor_________ Heavy Labor_________

Health History

What treatment have you already received for your condition? Check all that apply.

Medications_______

Surgery_______

Physical Therapy_______

Chiropractic Services________

Other_______

Please list:____

Insurance

Primary Insurance: ______________________________

Patients Name:________________________________DOB:___________________________

ID Number:___________________________ Group Number:_________________________

Policy Holder:__________________________ Relationship to Policy Holder:______________

Secondary Insurance: ______________________________

Patients Name:______________________________ DOB:___________________________

ID Number:___________________________ Group Number:_________________________

Policy Holder:__________________________ Relationship to Policy Holder:______________

We are committed to providing you with the best care possible. In order to do this without compromising our patients; this policy has been implemented for each patient. If you have medical insurance, we are anxious to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

You must realize however:
1. Your insurance is a contract between you, your employer, and the insurance company
2. Our fees are generally considered to fall within the acceptable range by the most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.
4. We will not compromise patient care based on an insurance companies "fee schedule"
5. Verification of your insurance benefits is not a guarantee that payment will be made.

We must emphasize that as a medical provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you!

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Patient Signature

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Date