Cornish Family Chiropractic

1911 4th St SW, Suite C | Mason City, IA 50401 *Today's Date*: _____

Name: *(Last, First, MI)* _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Cell:**_____ Verizon/US Cellular/AT&T/Sprint **Work:** _____

Email: _____ **Gender**: M / F **Marital Status:** Married / Single / Other

Social Security #: _____ **Date of Birth (mm/dd/yy)** _____

Student Status: *Full Time / Part Time / Non-Student* **Employer:** _____

*Referred by: _____ **Occupation:** _____

Financial Information: ( ) Insurance ( ) Worker's Comp ( ) Cash ( ) Personal Injury/Auto ( )Other

Primary Insurance

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Insured's Name _____ **M / F**

Address:_____

City: _____ **State:** _____ **Zip**: _____

Phone: _____ **Date of Birth**: _____

Secondary Insurance

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Insured's Name _____ **M / F**

Address:_____

City:_____ **State:** _____ **Zip**: _____

Phone: _____ **Date of Birth**: _____

Who is responsible for payment? Self / Other _____*(Relationship)*_____

Full Name: _____ **Phone**: _____

Chiropractic Experience

Have you been adjusted by a chiropractor before? **Y / N**

Date of Last Visit: _____

Health Habits

Do you smoke? **Y / N**

Do you drink alcohol? **Y / N**

Do you drink coffee/tea/soda? **Y / N**

Do you exercise regularly? **Y / N**

Do you wear:

Heel Lifts / Sole Lifts / Inner Soles / Arch Supports

Supplements You Take

___ Multivitamin

___ Calcium / Magnesium

___ Vitamin D

___ Essential Fatty Acids / Fish Oil

___ Other _____

Other Medications _____

Past Health Information

Describe the reason for your visit today:

_____

When did this concern begin? _____

Major accidents or falls contributing to current problem? _____

Approximate date _____

MRI studies for current problem? Y/ N

Has this concern:

___ Gotten Worse ___ Stayed Constant ___ Come & Gone

Does this concern interfere with:

___ Work ___ Sleep ___Daily Routine ___Other Activities

Type of discomfort

Dull / Sharp / Achy / Throbbing / Numb / Deep

Severity (1-10) _____

Amount of time you experience concern?

Constant (75-100%) ***Frequent*** (50-75%) ***Intermitant*** (10-50%)

Has this concern occurred before? Y / N

Is there someone we may thank for referring you to our office?

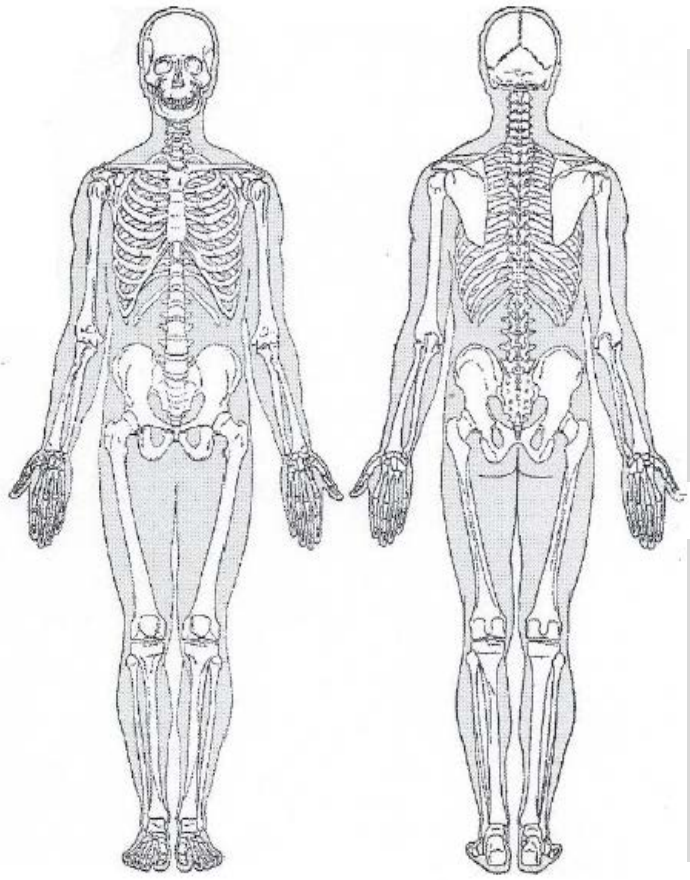
_____

Have you seen or heard of our office beacuse of:

___ *Sign* ___ *Community Event* ___ *Mailing* ___ *Social Media*

Additional Notes / Comments:

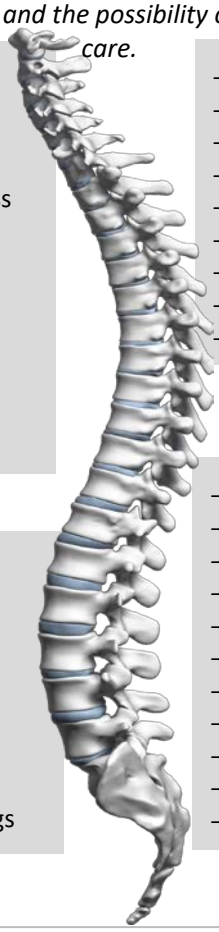
Please indicate areas of concern:



Please check each of the diseases or conditions that you have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

__Thyroid Problems
__Sore Throat
__Stiff Neck
__Radiating Arm Pain
__Hand/Finger Numbless
__Asthma
__Allergies
__High Blood Pressure
__Low Blood Pressure
__Heart Murmer
__Pacemaker
__Acid Reflux

__Headaches
__Migraines
__Dizziness
__Sinus Problems
__Allergies
__Fatigue
__Head Colds
__Vision Problems
__Difficulty Concentrating



__Constipation
__Colitis
__Diarrhea
__Gas Pain
__Irritable Bowel
__Bladder Problems
__Menstrual Problems
__Low Back Pain
__Pain/Numbness in Legs

__Middle Back Pain
__Congestion
__Difficulty Breathing
__Bronchitis
__Pneumonia
__Gallbladder Conditions
__Stomach Problems
__Diabetes
__Gastritis
__Hepatitis
__Kidney Problems

Women

Are you pregnant? Y / N When is your due date? _____
Are you nursing? Y / N Are you taking birth control? Y / N
Do you experience painful periods? Y / N
Do you have regular cycles? Y / N
Do you have breast implants? Y / N

Major Surgeries/Operations

__ Appendectomy __ Tonsillectomy
__ Gall Bladder __ Hernia
__ Back Surgery __ Broken Bones

Other

FUNCTIONAL ASSESMENT

Please report any limitations that you are experiencing. Please note that this form is important as it helps us to document Medical Necessity which helps determine whether or not your insurance company is liable for coverage. ***DO NOT SKIP OVER***

Check the best statement that applies:

1. Standing
__ I can stand as long as I want
__ I can stand for 60 mins w/out pain
__ I can stand 45-60 mins w/out pain
__ I can stand 20-45 mins w/out pain
__ I can stand 5-20 mins w/out pain

2. Sitting
__ I can sit as long as wanted w/out pain
__ I can sit 6 or more hrs w/out pain
__ I can sit 4 or more hrs w/out pain
__ I can sit 2 or more hrs w/out pain
__ I can sit 1 hour w/out pain

3. Walking
__ I can walk as long as desired w/out pain
__ I can walk 1 or more miles w/out pain
__ I can walk 1/2 mile w/out pain
__ I can walk 1 block w/out pain

Patient Signature _____

Thank you for choosing Cornish Family Chiropractic for your wellness! We look forward to working withyou.

Cornish Family Chiropractic

1911 4th St SW, Suite C, Mason City IA 50401

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read a copy of this office's HIPPA Notice of Privacy Practices.

{Please Print Name} {Signature} {Date}

OR

{Signature of Representative/Guardian}

Authority of Representative/Guardian

__ Parent __ Guardian __Power of Attorney

__Other _____

Consent for Treatment

I hereby grant Dr. Brett Cornish authority to perform any chiropractic care as he deems necessary or advisable for my diagnoses and treatment, including diagnostic imaging.

{Patient or Parent of Minor} {Date} {Doctor's Initials}

Financial Policy

- Payment for services is due at the time services are rendered
  - We accept cash, checks, Visa, MasterCard, and Discover
  - We reserve the right to collect before services are rendered
- All charges are your responsibility whether the insurance company pays or not
  - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage; however, our office staff will gladly assist you with verification to the best of our ability
  - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment
  - If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service or supply is denied, we may require you to follow up with your insurance company and/or pay the balance due
- Unless you are insured by Medicare or an insurance group which our doctor is a participating member, or double insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered
- If you are a member of an HMO or Managed Care Program, or have a PCP (Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your agreement with your insurance company
- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with the front desk to set up alternate payment options for your account

{Patient or Parent of Minor} {Date}