MANAGO CHIROPRACTIC

TO THE NEW PATIENT

Outline of Procedure for New Patients

1. STEP ONE: All new patients are requested to fill out a personal health history questionnaire.

2. STEP TWO: Your first consultation to discuss your health problems.

3. STEP THREE: Diagnostic chiropractic, orthopedic & neurological examination procedures to determine if chiropractic care is appropriate for your condition.

4. STEP FOUR: The Doctor will advise you as to the need of additional procedures such as laboratory & X-ray tests, if necessary.

5. STEP FIVE: If your case requires immediate attention, emergency first aid will be administered.

6. STEP SIX: You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

7. STEP SEVEN: After you return and receive your report of findings your recommended treatment program will be explained to you.

8. STEP EIGHT: Treatments will begin and continue as scheduled until your condition has been fully corrected or until the maximum possible improvement has been obtained.

PATIENT INFORMATION FORM

❑ New Patient ❑ New Case ❑ Change Only

First name: _____ Middle: _____ Last: _____

Address: _____ City _____ State _____ Zip Code _____

Home phone#: _____ Work #: _____ Cell#: _____

E-mail: _____

Your social security number: _____ _____ _____

Your birthdate: _____ _____ _____ ❑ Male ❑ Female

Your Employer: _____

Is insurance through your employer? _____

Type of Insurance:

❑ I don't have insurance, I will be paying cash.

❑ I have an HMO that doesn't cover this type of care.

Who is the primary insured? Name: _____

Relationship to you ❑ My spouse ❑ Parent ❑ Other _____

Primary insured's social security number: _____

Primary's date of birth: _____/_____/_____

Is this insurance through a company or an individual private policy? _____

If it is through a company, what is the name of the company? _____

Accident related? ❑ Yes ❑ No Accident State _____

Work related? ❑ Yes ❑ No Employer when injured: _____

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Insurance Co.:_____ Address: _____ City/State/Zip _____ Phone: _____ Member ID #_____ Group #_____ Primary insured person: _____ Relationship to me: _____	Insurance Co.:_____ Address: _____ City/State/Zip _____ Phone: _____ Member ID #_____ Group #_____ Secondary insured person: _____ Relationship to me: _____

FOR OFFICE USE ONLY

Diagnosis 1) _____ _____

Diagnosis 2) _____ _____

Diagnosis 3) _____ - _____

Diagnosis 4) _____ - _____

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ❑ Appendicitis
- ❑ Alcoholism
- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Eczema
- ❑ Epilepsy
- ❑ Goiter
- ❑ Heart Disease
- ❑ Influenza
- ❑ Lumbago
- ❑ Malaria
- ❑ Measles
- ❑ Mental Disorder
- ❑ Mumps
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Small Pox
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Venereal Infection
- ❑ Whooping Cough

CHECK ANY YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult Chewing/Clicking Jaw

❑ **NERVOUS SYSTEM CODE**

- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depressions
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Excessive thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Gall Bladder Problems

❑

❑ **GENERAL CODE**

- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

GENITO-URINARY CODE

- ❑ Bladder Trouble
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

C-V-R CODE

- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling

GASTRO-INTESTINAL CODE

- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Gall Bladder Problems
- ❑ Liver Trouble
- ❑ Weight Trouble
- ❑ Gas/Bloating After Meals
- ❑ Abdominal Cramps
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

EENT CODE

- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose
- ❑ Sore Throat

MALE/FEMALE CODE

- ❑ Menstrual Irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal Pain/Infections
- ❑ Breast Pain/Lumps
- ❑ Prostate/Sexual Dysfunction

FEMALES ONLY

When was your last period? _____

Are you pregnant? ☐ Yes ☐ No

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your Doctor considers your needs and desires when recommending your treatment program.

Please check the type of care you desire so that we may be guided by your wishes whenever possible.

❑ Relief Care ❑ Corrective Care ❑ Comprehensive Care ❑ Check here if you want the Doctor to select the type of care appropriate for your condition.

_____/_____/_____ X _____
Date Patient's Signature

If this is an accident related injury, please fill out the Accident Questionnaire next.

THE PURPOSE OF OUR CHIROPRACTIC CENTER

IS TO SUPPORT EACH INDIVIDUAL

IN ACHIEVING THEIR OPTIMUM HEALTH

AND TO

EDUCATE THEM SO THAT THEY MAY

UNDERSTAND HEALTH, AND CHIROPRACTIC,

AND IN TURN EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature X_____ SS#_____-_____-_____ Date____/____/_____

Guardian or Spouse's
Signature Authorizing Care_____ Date____/____/_____