Bloink Chiropractic
Welcome

Today's Date: _____ File No. _____

Patient's Name _____ Preferred Name _____

Birth Date _____ Age _____ □ Male □ Female SS# _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Phone to be called: □ Home □ Work □ Cell Email address _____

□ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse's Name_____ Children? □ Yes □ No How many? _____

Referred by: _____

Employer _____ How Long? _____

Employer Address _____ City/State/Zip _____

Occupation _____

Primary Insurance Co. _____

Address _____ City/State/Zip _____

Insurance Phone No. _____

Policy No. _____ Group No. _____

Name of Insured _____ Relation _____

Date of Birth _____ Insured's Employer _____

Secondary Insurance Co. _____

Address _____ City/State/Zip _____

Insurance Phone No. _____

Policy No. _____ Group No. _____

Name of Insured _____ Relation _____

Date of Birth _____ Insured's Employer _____

In the event of an emergency, contact _____ Relation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Physician _____ Phone _____

Person responsible for account: _____ Relation _____

Address _____ City/State/Zip _____

SSN _____ DL # _____ Work Phone _____

Payment method: □ Cash □ Check □ Credit Card

_____ I authorize assignment of my insurance rights and benefits directly to Bloink Chiropractic for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

Patient Name _____

Weight _____ Height _____

What is your reason for visiting us today? _____

_____

Please describe the pain and location? _____

_____

When did it begin? _____ Is it □ Better □ Worse □ Comes and goes □ Constant

Is this condition interfering with your □ Work □ Sleep □ Daily routine

If so, please explain _____

Have you had this or similar conditions in the past? □ Yes □ No

If yes, please explain _____

Have you been treated by a medical physician for this condition? □ Yes □ No

If so, where? _____

Have you been treated by a Chiropractor before? □ Yes □ No

If so, whom? _____ Phone No. _____

Are you taking any of the following medications?

□ Nerve pills □ Muscle relaxer □ Stimulants □ Pain killer (including aspirin
□ Blood thinner □ Tranquilizer □ Insulin □ Other _____

Do you have or ever had any of the following diseases or conditions?

□ Heart Attack/Stroke □ Heart Surg/Pacemaker □ Heart Murmur □ Congenital Heart Defect
□ Mitral Valve Prolapse □ Artificial Valves □ Alcohol/Drug Abuse □ Venereal Disease
□ Hepatitis □ HIV+/Aids □ Shingles □ Cancer
□ Frequent Neck Pain □ Emphysema/Glaucoma □ Anemia □ High/Low Blood Pressure
□ Psychiatric Problems □ Rheumatic Fever □ Kidney Problems □ Sever/Frequent Headaches
□ Ulcers/Colitis □ Fainting/Seizures/Epilepsy □ Sinus Problems □ Asthma
□ Diabetes/Tuberculosis □ Difficulty Breathing □ Chemotherapy □ Lower Back Problems
□ Artificial Bones/Jones □ Arthritis

List any allergies _____

List any surgeries/treatments with dates _____

List any **past** serious accidents with dates _____

Family health history _____

Do you take supplements or vitamins □ Yes □ No Exercise? □ Yes □ No

Are you on a special diet? □ Yes □ No Since (date) _____

Do you smoke? □ Yes □ No If yes, how much? _____ How long? _____

Are you wearing □ Heel lifts □ Sole lifts □ Inner soles □ Arch supports

What is the age of your mattress? _____ Is it comfortable? □ Yes □ No

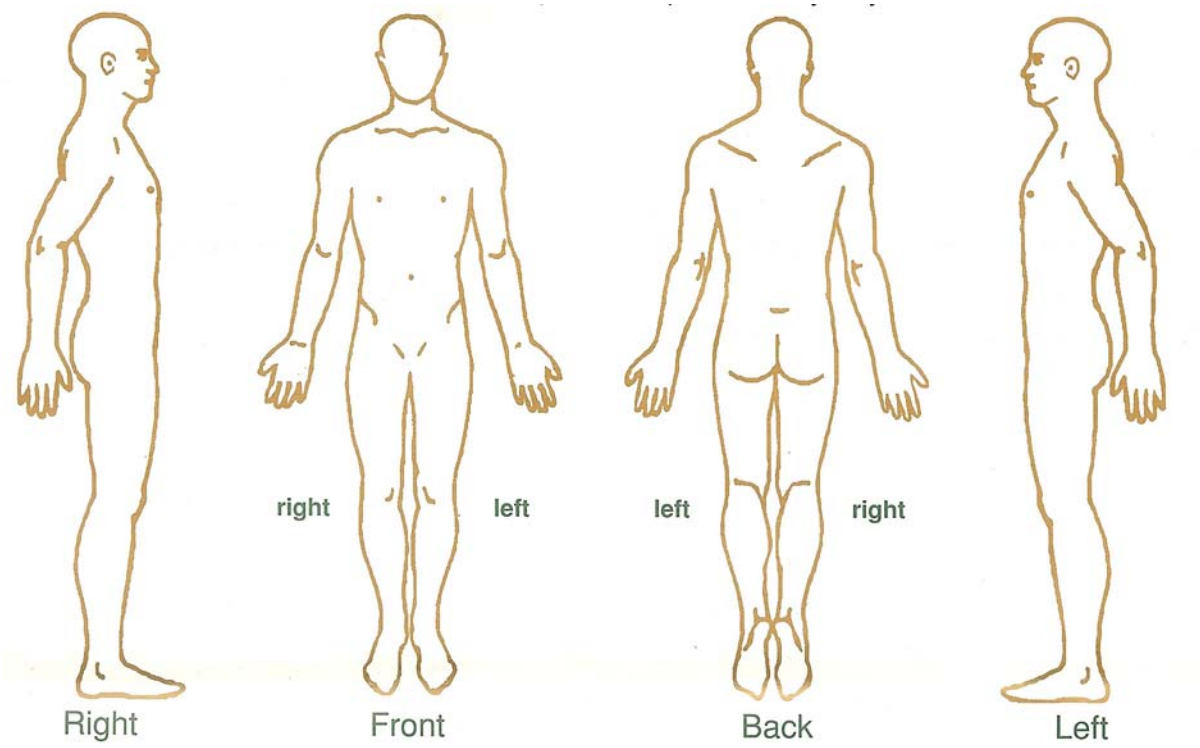
For women: Are you taking birth control? □ Yes □ No

Are you pregnant? □ No □ Yes/How long? _____ Nursing? □ Yes □ No

Please tell us where your injury or discomfort is located. Please mark all areas with the appropriate letter and/or degree of pain. Please use the following abbreviations:

Numbness	NNNN
Pins and Needles	PPPP
Burning	BBBB
Aching	AAAA
Stabbing	SSSS

Indicate on a scale of 1 (discomfort) to 10 (extreme pain)



Bloink Chiropractic
Substance Survey Form

Name_____ **Date_____**

Please list any prescription medications you are currently taking or have taken in the last year:

Medication	Diagnosis

List any over the counter medication you are currently taking or have taken in the last year

Product	Symptoms	Quantity & Frequency

Please list any vitamins, supplements, herbs or homeopathic medicines you are currently taking or have taken in the last year (use other side if needed)

Product	Symptoms	Quantity and Frequency

Check the following items that apply to you and indicate the amount used

Coffee _____ Artificial-sweetener _____ Ice Cream _____

Tea _____ Antacids _____ Alcohol _____

Soft drinks _____ Laxatives _____ Cigarettes _____

Diet Soft Drinks _____ Candy _____ other tobacco products _____

How many desserts do you have in an average week? _____

Financial Policy

Insurance Coverage

Welcome to Bloink Chiropractic. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage, for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and /or a deductible. For example if you have a deductible of $100, and you insurance pays 80% you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private pay: Please initial

A_____ As I have no, insurance I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance Please initial

C_____ I would like this clinic to bill my insurance. I understand I am responsible for the cost of treatment.

Missed Appointments

It is the policy of Bloink Chiropractic to assess a $25 missed visit fee to patients who do not cancel appointments and do not show up. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result I a time lost that could have been used to provide care for others.

_____ My initial here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

_____ _____

Signature Date