

Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions to the best of your knowledge. If you need help please ask the receptionist.

PLEASE PRINT.

Name: _____ Today's Date: _____

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

Home Phone: _____ Cell phone: _____ Work Phone: _____

Age: _____ D.O.B. : _____ Marital Status: S M W D

Social Security Number: _____ Email: _____

In Case of Emergency

Name: _____ Relationship: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Employer: _____ Occupation: _____ Yrs. On Job: _____

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

Insurance Provider: _____ Member ID #: _____

Plan/Group #: _____ Primary Person Insured: _____

D.O.B. : _____

S.S.N.: _____ Employer Name: _____

Secondary Insurance Provider: _____ Member ID #: _____

Plan/Group #: _____ Primary Person Insured: _____

D.O.B. : _____

S.S.N. : _____ Employer Name: _____

How did you hear about us: TV / Radio / Sign / Friend or Family / Flyer / Other _____

If referred, please tell us who we can thank: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. 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: _____ **Date:** _____

Spouse or Guardian Signature: _____ **Date:** _____

Notice to New Patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made prior to seeing the doctor.

Total Body Chiropractic

patient's name

contract number

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AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

signature

witness

date

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.

signature

witness

date

Authorization to Pay
Release Authorization
is granted to
Physician Tax ID.

Total Body Chiropractic
106 East Enon Springs Road
Smyrna, TN 37167
26-3797524

Total Body Chiropractic

**CONSENT FOR TREATMENT
AND
AUTHORIZATION TO PERFORM X-RAYS**

Date _____
Time _____ AM PM (circle one)

Diagnostic x-rays may be necessary in my case so that a complete analysis can be made of my present musculoskeletal problem or illness.

I authorize Dr. Mark Franicevic to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem or illness.

Signed: _____

To the best of my knowledge I am NOT pregnant and that the above named doctor has my permission to x-ray me for diagnostic interpretation.

Signed: _____

Health Questionnaire

Name: _____ Date: _____

1. Please list all medical complaints in order of importance:

2. Please list all prescription medications you are taking:

Name of Medication

Reason for Medication

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3. List Vitamins and Supplements you are currently taking:

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4. Please list all surgeries and the year they were performed:

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5. Family History

Age

Health Issues and/or cause of death

Mother:

Father:

Mother's Mother:

Mother's Father:

Father's Mother:

Father's Father:

Brothers:

Sisters:

Children:

6. Please check the Conditions you have or have had:

- | | | |
|-------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Muscular Dystrophies |
| <input type="checkbox"/> Allergic Rhinitis (nose irritation, hay fever) | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> ALS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteomyelitis |
| <input type="checkbox"/> Alzheimers Disease | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Embolism | <input type="checkbox"/> Parkinsons Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Pneumonia, Whooping Cough |
| <input type="checkbox"/> Arterial Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Ashtma | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Psychotic or Schizophrenic Disorders |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pulmonary Heart Disease |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Benign Tumors | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Hernia | <input type="checkbox"/> Septicemia |
| <input type="checkbox"/> Bowel Obstruction/Blockage | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> HIV sero-positive | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Human Papillomavirus (HPV) | <input type="checkbox"/> Spondylolithiasis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Subdural hematoma |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Ileitis | <input type="checkbox"/> Thyroid Gland-hyper/hypo |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cervical Spine Bifida | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Macular Eye Degeneration | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Thrombophlebitis |

7. Miscellaneous

Social History

- Smoking
- Other Tobacco Use
- Alcohol Use
- Drug Use
- Drink Coffee/Tea
- Diet is: Balanced / Not Balanced
- Rest is: Sufficient / Not Sufficient
- Recreation is: Sufficient / Not Sufficient
- My Family Stress is: Severe / Moderate / Minimal / None
- How do you like work: I love it / It's OK / I hate it
- My Job Stress is: Severe / Moderate / Minimal / None

8. Please list all present symptoms for the Musculoskeletal System

Head

- Frequent headaches
- Severe headaches
- Head feels heavy
- Vertigo
- Light Headed
- Loss of smell
- Loss of taste
- Loss of balance
- Dizziness

Neck

- Pain in Neck
- neck pain with movement
- swelling in neck
- Stiff neck
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Limited neck movement

Arms /Hands

- Pain in upper arm
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins and needles
 - in arms
 - in fingers
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Loss of grip strength

Mid Back

- Mid back pain
- Pain between shoulder blades
- Sharp stabbing pain
- Dull Ache
- Pain from front to back
- Pain over kidney area
- Muscle spasms in mid back

Low Back

- Low back Pain
- Low back feels out of place
- Muscle spasms in low back

Hips/Legs/Feet

- Pain in buttocks
- Pain down leg
- Knee Pain
- Leg cramps
- Pins & Needles in legs
- Numbness in leg
- Numbness in toes
- Cold feet
- Swollen ankles
- Swollen Feet

Shoulders

- Pain in shoulders R/L
- Pain across shoulders
- Tension in shoulders
- Muscle spasms shoulders
- Cant raise arms
 - above shoulder level
 - over head

9. Have you ever been in an accident: yes/no

When was the Accident: _____ Injuries: _____

Type of Accident: Auto/Work-On Job/ At Home/Other

Total Body Chiropractic

Office Policies

- A \$40 NSF check fee will be charged for all returned checks.
- All out of pocket estimates given are **estimates only!** Although, we try and give the most accurate estimate of insurance benefits possible, we will not know how your insurance will pay until we receive payment from them. If there is a balance on your account after insurance has paid, it will be owed by you.
- **It is the patient's responsibility to know their own insurance benefits.** As a courtesy to our patients, we will be happy to verify any insurance and file any claims, but this does not guarantee payment.
- All deductibles, co-pays and patient portions will be **due on the date of service.**
- A 25% fee will be added to any account that is sent to a collection agency. This fee will then be owed by the patient.
- A \$50.00 fee will be added to your bill for a no call/no show on scheduled appointments.

I, _____, HAVE READ, UNDERSTAND AND ACCEPT THE ABOVE POLICIES OF TOTAL BODY CHIROPRACTIC.

Signature: _____ Date: _____

Witnessed by: _____ of Total Body Chiropractic

Date: _____