Barczyk Spine & Joint

Acct #: _____ Date: _____

Patient Name: _____ DOB: _____

Circle one: Male Female SSN: _____ Height: _____ Weight: _____

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

Primary phone: _____ Alternate Phone: _____

Email: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current complaint(s): _____

Are these symptoms/conditions related to, or the result of:

☐ auto collision ☐ work-related injury ☐ slip+fall ☐ none DOI: _____

Any prior treatment related to this injury? ☐ Yes ☐ No

Where was this treatment done? _____

Updated 7/25

Occupation: _____ Employer: _____

Primary Care Physician: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Have you ever been under chiropractic care? ☐Yes ☐No If yes, where? _____

Please list any surgeries you have had.

_____ When? _____

_____ When? _____

_____ When? _____

_____ When? _____

Please list any medical conditions you have.

_____

_____

_____

Do you have a pacemaker? ☐ Yes ☐ No

Do you consume alcohol? ☐Yes ☐ No | Tobacco? ☐Yes ☐No ****Females:** Last menstrual cycle? _____

Please list any medications you are currently on (Rx, OTC, and recreational).

_____

_____

_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits with the about mentioned, and hereby assign at clinic's request, and convey directly to **Barczyk Spine & Joint** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above-named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan, any claim, chose in action, or other right I may have to such insurance and or/employee health care benefits coverage under any applicable insurance policies and or/employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and or/employee health care plan, including, if necessary bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this assignment.

_____

Signature of Insured/Guardian Date