New Patient Form

PATIENT INFORMATION

Appointment Date: ___________________________________

Patient Name: ___________________________________

Street Address: ___________________________________

____
City State Zip Code

Height: _____ Weight: _____ ☐ Left-Handed ☐ Right-Handed

Age: _____ Date of Birth: _______________ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient Occupation: ___________________________________

Employer: ___________________________________

Employer Address: ___________________________________

Employer Phone: ___________________________________

Spouse Name: ___________________________________

Spouse Date of Birth: ___________________________________

Spouse Occupation: ___________________________________

Spouse Employer: ___________________________________

Number of Children: ___________________________________

Who may we thank for referring you?: ____________________

CONTACT INFORMATION

I wish to be contacted in the following manner *(please check all that apply)*:

☐ Home Phone: ___________________________________
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Phone: ___________________________________
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Cell Phone: ___________________________________
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Email Address: ___________________________________

☐ Written Communication: ___________________________
- ☐ Okay to mail my home address
- ☐ Okay to mail my work/office address
- ☐ Okay to fax to this number: ____________________

Emergency Contact Name: ___________________________

Relationship: ___________________________________

Home Phone: ___________________________________

Cell Phone: ___________________________________

Work Phone: ___________________________________

INSURANCE INFORMATION

Insurance Company: ___________________________________

ID / Group Number: ___________________________________

Primary Insured: ___________________________________

Date of Birth: ___________________________________

Relationship to Patient: ___________________________

Is patient covered by secondary insurance? ☐ Yes ☐ No

Insurance Company: ___________________________________

ID / Group Number: ___________________________________

Subscriber Name: ___________________________________

Date of Birth: ___________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I *(or my dependent)* have insurance coverage with ___________________________ and assign direcly to Champion Health Associates, LLC all insurance benefits, if any, otherwise payable to me for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Yes ☐ No Date: ____________ Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Workers' Compensation ☐ Other

Attorney Name *(if applicable)*: ___________________________________

CHAMPION HEALTH

PATIENT CONDITION

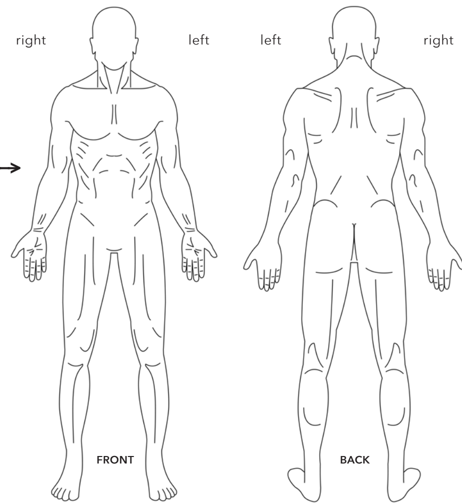
Reason for Visit: ____

____

When did your symptoms appear? ______________________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the diagram where you continue to have pain, numbness, or tingling ⟶



Rate the level of your pain on a scale from **1** *(least pain)* to **10** *(severe pain)*: ______

Pain Type: ☐ Sharp ☐ Numbness ☐ Burning ☐ Stiffness ☐ Dull ☐ Aching ☐ Tingling ☐ Swelling ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Other

How often do you have this pain? ______________________________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other

Name and address of the doctor(s) who have treated you for your condition: ______________________________

Date of last: Physical Exam ____________ Spinal X-Ray ____________ Blood Test ____________

Spinal Exam ____________ Chest X-Ray ____________ Urine Test ____________

Dental X-Ray ____________ MRI, CT Scan, Bone Scan ____________

Exercise	**Work Activity**	**Habits**		
☐ None	☐ Sitting	☐ Smoking	☐ Alcohol	☐ Other ________
☐ Moderate	☐ Standing	*Packs/day:* ________	*Drinks/week:* ________	________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Beverages	☐ High Stress Level	________
☐ Heavy	☐ Heavy Labor	*Cups/day:* ________	*Reason:* ________	________

Injuries/Surgeries	Description	Date
Falls:	________	________
Head Injuries:	________	________
Broken Bones:	________	________
Dislocations:	________	________
Surgeries:	________	________
Relevant Family History:	________	________

Are you pregnant *(female patients only)*? ☐ Yes ☐ No ☐ N/A Due Date: ______________________

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________

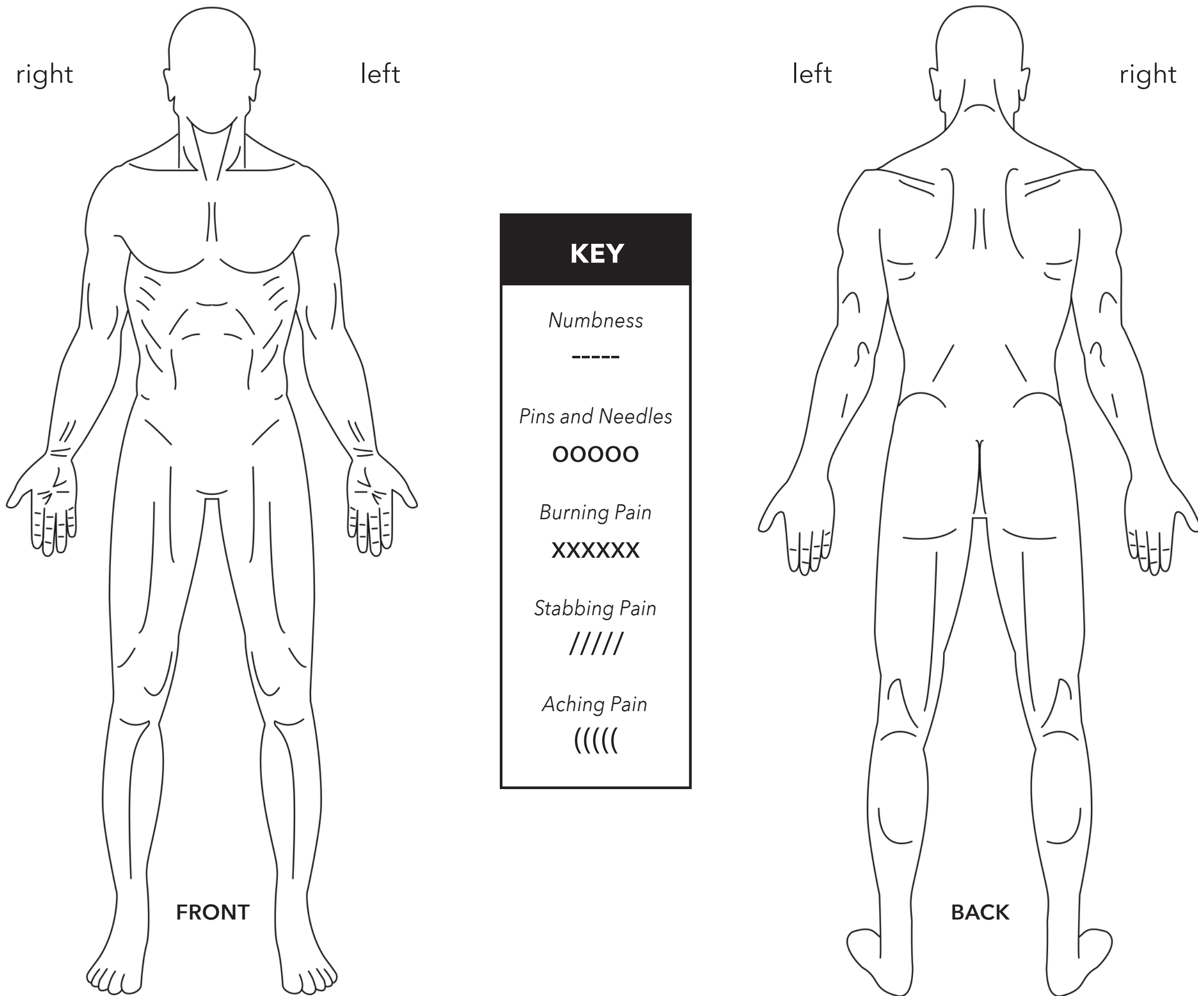
Patient Signature: ______________________ Date of Birth: ____________ Today's Date: ____________

Champion Health Associates, LLC / 9240 Explorer Drive, Suite 215 / Colorado Springs, CO 80920 / phone 719-473-7000 / fax 719-473-7479

Pain Diagram

Patient Name:_____________________________ Date of Birth:____________ Today's Date: ___________

Please be sure to fill out the diagram below extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.



Visual Analogue Scale

Please mark on the lines below the level that most accurately represents your pain:

Right Now:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*	At Best:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*
Average Pain:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*	At Worst:	0 1 2 3 4 5 6 7 8 9 10 *No pain* *Unbearable pain*

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your Protected Health Information will be used by Champion Health Associates, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- *You may request a restriction on the use or disclosure of your Protected Health Information.*
- *This office may or may not agree to restrict the use or disclosure of your Protected Health Information.*
- *If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.*

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____

Patient or Legally Authorized Individual Signature *Date*

____

Print Patient's Full Name *Time*

____

Witness Signature *Date*

Financial Policy

We are doing everything possible to hold down the cost of chiropractic care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

All payment is expected at time of service.

Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes co-payments and deductibles. We gladly accept cash, checks, or credit cards.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

Those insured under Personal Injury Protection *(i.e. auto accidents)* or Workers' Compensation, are required to complete specific forms pertaining to their situation.

For those patients who have insurance coverage, we will be happy to fill out and submit claims at no additional charge. If our office is filing your insurance claims, payment in full is not required on the date of service. If, however, you choose to submit your own claims, payment in full is required at the time of service.

We will verify your chiropractic insurance benefits as a courtesy, however it is not a guarantee of benefits. Those covered by general insurance are responsible for the patient portion *(i.e. deductibles, co-pays, etc.)* when services are rendered.

Insurance patients who neglect to supply our office with necessary information/forms within a reasonable amount of time will be responsible for payment in full.

I have read and understand the above stated financial policy. I agree to assign insurance benefits to the office whenever necessary. I also agree that if it become necessary to forward my account to a collection agency, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collection.

Signature: ________________________________ Date of Birth: ___________ Today's Date: ___________