New Patient Form

CHAMPION HEALTH

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

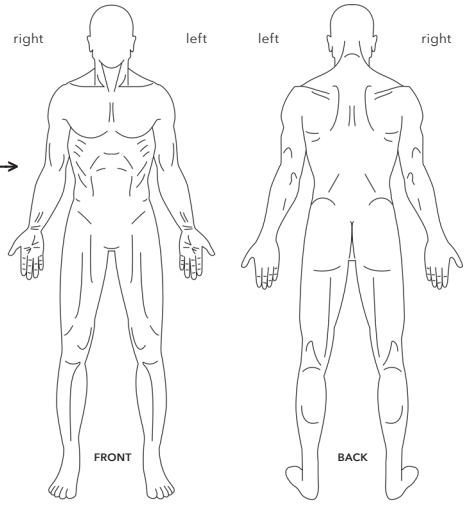
Reason for Visit: _____

_____

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	☐Dull	☐Throbbing
☐Numbness	☐Aching	☐Shooting
☐Burning	☐Tingling	☐Cramps
☐Stiffness	☐Swelling	☐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

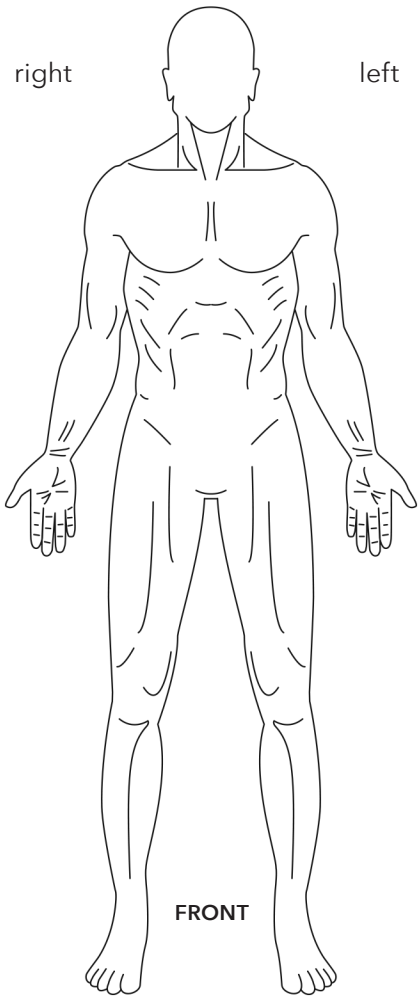
Patient Signature: _____ Date of Birth: _____ Today's Date: _____

Pain Diagram

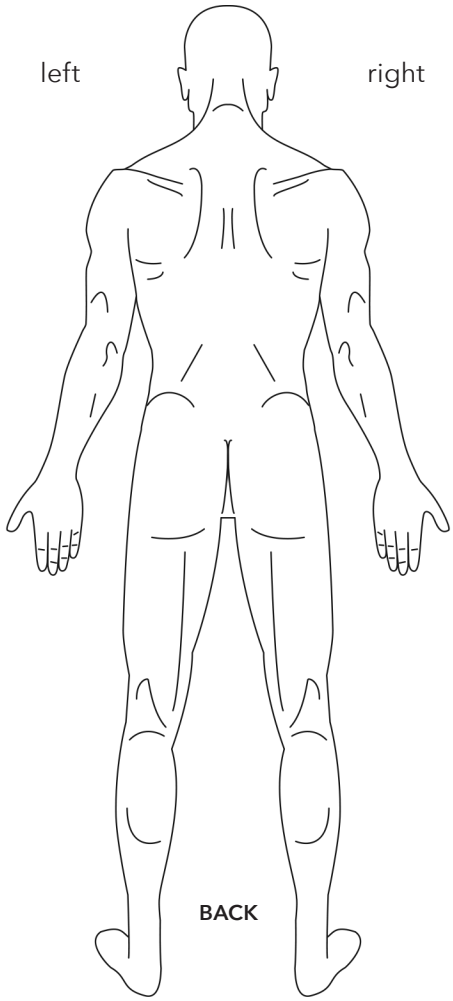
CHAMPION HEALTH

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.



KEY	
Numbness	-----
Pins and Needles	OOOOO
Burning Pain	XXXXXX
Stabbing Pain	/////
Aching Pain	(((((



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*

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

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

CHAMPION HEALTH

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 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: _____