NEW/RE-ESTABLISHED PATIENT FORMS

THESE ARE THE FORMS THAT MUST BE FILLED OUT BEFORE YOUR APPOINTMENT:

- **PERSONAL INFORMATION QUESTIONNAIRE**-Fill out all four (4) pages of the questionnaire, the doctor will review this before your consult; provide us with as much information as possible in order to better grasp your condition.

- **PATIENT POLICIES**- Read through the patient policy, sign and date.

- **ASSIGNMENT AND INSTRUCTION OF DIRECT PAYMENT**- This form states that you allow us to receive direct payment from your insurance company for the dates of services we provide. We can fill out the top portion when you come in, just sign and date.

- **HEALTH INSURANCE**-We will fill out this form when you come in for your appointment, we will fill it in with your benefits for both Chiropractic and Physical Therapy.

If you have any questions concerning the paperwork,
Do not hesitate to give us a call at 703-938-7555
M T TH F 11-7, Wed 3-7, and Sat 10-1

FAMILY CHIROPRACTIC CENTER OF OAKTON

CONFIDENTIAL PATIENT INFORMATION

Date________________________

First Name______________________________ M.I.______ Last Name________________________________

Address____

City____ State________ Zip ____________

Home Phone (____) ______________________________ Work Phone (____) ______________________________

Birthdate_____ - _____ - _____ Age_______ Sex M F Social Security Number_______ - _______ - __________

Employer ____________________________________ Occupation ____________________________________

Name of Spouse ______________________________ Employer ______________________________________

Occupation __________________________________ Work Phone (____) ______________________________

~~Nearest Relative~~ _______________________________ Phone (____)__________________________________

Referred to this office by ____

How do you prefer to be addressed: Mr. Mrs. Miss Ms. Dr. First Name

ACCOUNT INFORMATION

☐ Worker's Compensation ☐ Personal Injury/Car Accident ☐ Health Insurance ☐ Medicare

☐ Other ____

Insurance Company____Phone (____) ____________________

Address______________________________City____________________________ State_______ Zip __________

~~Identification Number~~____________________________ Group Name and Number __________________________

Insured Person's Name (If different than patient) ____

Insured's Social Security Number________ - ________ - ______________ Insured's Date of Birth:_________________

Insured's Employer (If Worker's Compensation) ____________________ Sex: ____________ Phone: _________________

Address____

Patient's Relationship to Insured: Self Spouse Child Other

My account will be paid today by: Cash Check Charge

HEALTH INFORMATION

Have you had previous chiropractic care? ______________________________

Where? ______________________________ When? ______________

What is your major complaint? ______________________________

Other complaints ______________________________

When and how did your major complaint first appear? ______________________________

____

How long have you had this condition? ______________________________

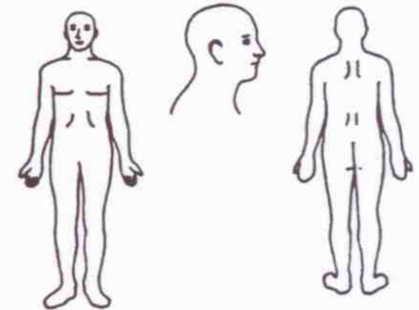
Have you had this or similar conditions in the past? ☐ Yes ☐ No

When? ______________________________

Other doctors who have treated this condition: ______________________________

____

Please mark your areas of pain on the figures below.



Since this condition began, is it: ☐ Better ☐ Worse ☐ Unchanged

What part of the day is most painful? ______________________________

Please check the appropriate box to describe your present limitations in function:

Activity	Normal	Mildly Limited	Moderately Limited	Severely Limited
Lifting	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Running	☐	☐	☐	☐
Resting in Bed	☐	☐	☐	☐
Intercourse	☐	☐	☐	☐
Other ____________	☐	☐	☐	☐

SOCIAL HISTORY

Present Occupation ______________________________ How long have you had this job? ______________

Type of activity involved: ☐ Sitting ☐ Moderately Active ☐ Heavy Labor

List any previous jobs during the past two years (specify dates) ______________________________

Activity when not working ______________________________

Please list the sports or physical activity you participate in ______________________________

How often? ☐ More than once a week ☐ Once a week ☐ Once a month

Age of mattress ______________ (Comfortable? or Uncomfortable?)

In which position do you sleep?

☐ Stomach ☐ Right Side ☐ Left Side ☐ Back ☐ Other

Have You Ever:	*Yes*	*No*	*Do You:*	*Yes*	*No*	
Been knocked unconscious	☐	☐	Now take any medications	☐	☐	Type ____________
Used a cane, crutch, other support	☐	☐	Take vitamins or minerals	☐	☐	Type ____________
Been treated for a spine or nerve disorder	☐	☐	Smoke	☐	☐	Amount __________
Had any mental disorder	☐	☐	Drink	☐	☐	Amount __________
Had any surgery	☐	☐	Have any drug allergies	☐	☐	Type ____________

Describe______________________________

FAMILY HISTORY

(Place the family member's corresponding number on the line before the disease they have or had)

1. Self 2. Father 3. Mother 4. Brother(s) 5. Sister(s) 6. Grandfather 7. Grandmother 8. Uncle 9. Aunt

________ Diabetes	________ High Blood Pressure	________ Dizziness
________ Cancer	________ Low Blood Pressure	________ Stroke
________ TB	________ Hypoglycemia	________ Arteriosclerosis
________ Heart Disease	________ Thyroid	________ Anemia
________ Arthritis	________ Backaches	________ Epilepsy
		________ Pleurisy

Have you ever been involved in an auto accident?

Past year______ Past five years______ Over five years______ Never______

Describe:____

____

Have you had any personal injury or accident?

Past year______ Past five years______ Over five years______ Never______

Describe:____

____

Date of last physical examination: ______________________________

How would you characterize yourself: *(Check all those that apply)*

Normal______ Nervous______ Tense______ Depressed______ Cry easily______ Quick Temper ______

Other____

(OVER)

FOR WOMEN ONLY

Number of days from beginning of one period to the beginning of the next period________________

Date of last menstrual period________ How many days do you menstruate?________________

Are you pregnant? ☐ Yes ☐ No

Do you use: ☐ Birth Control Pills ☐ Diaphragm ☐ IUD

PRESENT REASON FOR CONSULTING THIS OFFICE

________ I have no specific problem; I understand the role of Chiropractic in my general health care and want to continue maintaining my health.

________ I have a symptom and am interested in help with this specific problem; I am interested in learning how Chiropractic care can improve my and my family's health.

________ I have a symptom and I am interested in help with this problem, and in learning how to prevent it in the future.

Additional information you would like the doctor to know:

DOCTOR'S NOTES

Patient Policies

Welcome to Family Chiropractic Center of Oakton P.C.

The purpose of this agreement is to allow us to completely serve you and get the best results in the shortest amount of time.

SIGNING IN: When you arrive, sign in and have a seat. Some one will be with you as soon as possible.

PAYMENT OF BILL: We will expect you to honor the financial agreement you make with our office. If you find that you can't fulfill the agreement you've made with us, advise our assistant immediately so new arrangements can be made. Should the bill not be paid a 1.5% service charge will be added every month from the last date of service treated. Our policy is that patients not have a cash balance. Insurance companies will be billed. If a check is sent to your home by your insurance company it should be brought or sent to our office within three (3) days. Please also send the papers that arrive with the check so we can tell which services were paid.

MISSING OR CHANGING APPOINTMENTS: We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we desire. Thus, if you need to change the time of your appointment, plan to come the same day. If the same day is not possible, be sure to make up the missed appointment within the week. If you cancel your appointment with less than 24 hours notice of the appointment time, you must reschedule the appointment for that week or pay a $25.00 fee.

MISSING A MASSAGE APPOINTMENT: Due to the limited time of our massage therapist, we do require that a massage appointment is cancelled 24 hours in advance, so someone else can schedule a massage. If you fail to cancel in advance, a fee will apply, equal to half the amount of the total massage.

**NOTE: Please speak to someone before the end of business day when canceling an appointment. Messages left on the answering machine will be considered a missed appointment and subject to the fee.

CHILDREN: Parents who are patients are encouraged to have their children/young adult checked by the doctor. **CASH PATIENTS ONLY:** The initial visit (with exam) is no charge if parent is a current patient. There is a charge for children/young adult s initial visit (with exam) without a parent being a patient. Please ask one of our assistants for details.

note: Patients with insurance can not apply cash plan to deductibles, co-pays or co-insurance payments.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered me will be immediately due and payable. If legal action is taken, all reasonable court costs, legal fees and any other fees associated with collections will be my responsibility.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of chiropractic adjustment throughout my spine. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. Even though rare, as with any treatment from any medical facility, there may be medical risks associated with treatment. It is my understanding of this and agree the Doctor will not be held responsible for any effects.

DATE____________________________

PATIENT__________________________

SIGNATURE________________________

Dr. Brian J. Tenshaw

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient: ____

Claim/Group #: ____

SS/ID#: ____

Employer: ____
(if Workers Comp.)

Date of Injury/Accident: ____

I hereby instruct and direct the ______________________ Insurance company to pay by check made out and mailed directly to:

Family Chiropractic Center of Oakton, P.C.
2972 – F Chain Bridge Road
Oakton, VA 22124

the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. <u>THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.</u> This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges if not paid in full by my insurance company (the contracted rate agreed upon between assignee and insurance company).

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to me as the following address:

c/o Family Chiropractic Center of Oakton, P.C.
2972 - F Chain Bridge Road
Oakton, VA 22124

I also authorize the release of any information pertinent to my case to any such insurance company to which this Assignment is addressed.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Dated at Oakton, Virginia this _________ day of ______________________, ___________.

______________________ Signature of Policyholder

______________________ Signature of Witness

______________________ Signature of Claimant (if other than policy holder)