Benessere Chiropractic

295 W. Broadway

Eugene, OR 97401

Ph: (541)636-3358 F: (541)636-3098

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| Chris Osterlitz,D.C. | Katherine Kinports, D.C. | Erik Gurule-Long, D.C. | Sarah Pagen,L.M.T. |
| Ann Cole, L.M.T. | Annie Siemens, L.M.T. |  |  |

 Patient Registration

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_Zip\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_\_\_\_\_M\_\_F\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_ email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: S M W D P Spouse’s Name\_\_\_\_\_\_\_\_\_\_ # of children\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am here today due to: \_Illness \_Trauma \_Work Injury \_Auto Accident \_Other

What date did this occur?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Insured Patients

Primary Insurance for today’s visit: \_Private Ins. \_Auto \_Work Comp \_Medicare

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group No:\_\_\_\_\_\_\_\_\_ Claim No:\_\_\_\_\_\_\_\_\_\_\_ Medicare No: \_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group No:\_\_\_\_\_\_\_\_ Claim No:\_\_\_\_\_\_\_\_\_\_\_ Medicare No: \_\_\_\_\_\_\_\_\_\_\_\_

I understand that health insurance policies are an arrangement between my insurance carrier and myself. Billing is done by Benessere as a courtesy only and all services rendered to me are my personal responsibility.

I authorize the release of any medical information necessary to process my insurance claim and I authorize payment of medical benefits to this office for professional services rendered.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Please check the symptoms that you have noticed in the last year:

 If other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this appointment related to an accident or injury? (If billing auto insurance, please ask receptionist for auto form) [ ] No [ ] Yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First priority for this appointment(body region):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had similar symptoms in the past? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition: [ ] Constant [ ] Getting progressively worse

 [ ] Comes and goes [ ] Getting progressively better

Other doctors seen for this condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response to treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second priority for this appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had similar symptoms in the past? When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition: [ ] Constant [ ] Getting progressively worse

 [ ] Comes and goes [ ] Getting progressively better

Other doctors seen for this condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response to treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Third priority for this appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had similar symptoms in the past? When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition: [ ] Constant [ ] Getting progressively worse

 [ ] Comes and goes [ ] Getting progressively better

Other doctors seen for this condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Response to treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fourth priority for this appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this condition start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had similar symptoms in the past? When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition: [ ] Constant [ ] Getting progressively worse

 [ ] Comes and goes [ ] Getting progressively better

Other doctors seen for this condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Response to treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been under chiropractic care? [ ] No [ ] Yes (names): \_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response to treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Techniques used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by a physician in the last year? [ ] No [ ] Yes

Name: \_\_\_\_\_\_\_\_\_\_\_ Treated for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Resolved: [ ] Yes [ ] No

Name: \_\_\_\_\_\_\_\_\_\_\_ Treated for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Resolved: [ ] Yes [ ] No

Name: \_\_\_\_\_\_\_\_\_\_\_ Treated for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Resolved: [ ] Yes [ ] No

Have you had any x-rays, MRI, CT scans in the past several years? [ ] No [ ] Yes:

Date Test Body Region Doctor/Testing Center

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take vitamins or minerals? [ ] No [ ] Yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever broken/fractured a bone?

Date: Bone/Region: Treatment: Residual symptoms:

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

Have you ever been involved in a car accident?

Date: Description: Injuries: Resolved:

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

Please list all surgeries or major illnesses.

Date: Description: Resolved:

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

Other injuries (falls, concussions, trauma):

Date: Description: Resolved:

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Yes [ ] No

 Heavy Moderate Light None Do you wear?

Alcohol [ ] [ ] [ ] [ ] [ ] Orthotics

Tobacco [ ] [ ] [ ] [ ] [ ] Heel lifts

Coffee [ ] [ ] [ ] [ ] [ ] Insoles

Exercise [ ] [ ] [ ] [ ] [ ] Arch supports

Sleep [ ] [ ] [ ] [ ]

Appetite [ ] [ ] [ ] [ ]

Pain Drawing

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Mark as follows:

A = Ache B = Burning N = Numbness P = Pins & Needles

S = Stabbing O = Other, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Policy

We require payment at the time of service. If you have private health insurance we ask that you pay your co-pay or co-insurance at the time of service. If you have a yearly deductible, you must meet that as your policy specifies. We will bill, or you may bill, your insurance company. If payment for any part of your treatment is denied by an insurance carrier you will assume full responsibility for payment and will pay independent of any appeal process with the insurance carrier.

In the case of either personal injury, auto accident, or workers’ compensation claims, we will bill the entire amount of each visit to your insurance company. Any services not covered by the insurance company are your responsibility. The cost of supplies, supports and/or supplements not paid for by your insurance company are your responsibility.

If you have any questions concerning our payment policy, please feel free to ask the receptionist.

Cancellation Policy

We require 24 hours notice for all cancellations. If you cancel with less than 24 hours notice, you will be charge 50% of the total charges for the scheduled visit. If you fail to keep your appointment and do not call to cancel, you will be charge IN FULL for the total visit. We make reminder calls as a courtesy, however, it is your responsibility to remember and come to your appointments.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

I have read and understood the above payment and cancellation policies and agree to follow them while utilizing the services at Benessere Chiropractic.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_