Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Name _____Home Phone _____Cell Phone _____

Social Security # _____Email Address: _____

Address _____City _____State _____Zip _____

Age _____ Birth-date _____ Marital Status: S M W D No. of Children _____

Please circle one payment type: Cash Check Master Card/ Visa

Your Employer _____Occupation _____Yrs. on Job _____

Employer Address _____City _____State _____Zip _____

Office Phone _____Do you have health ins. through your employer? Y or N

Insurance Company _____ Id # _____

Name of Spouse or Parent _____Birth-date _____

Spouse/Parent employed by _____Occupation _____Yrs. on Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone _____ Spouse SS# _____

Does your spouse or parent have health insurance at work? Yes _____ No _____

Describe the Major Complaints that bring you to our office _____

_____

_____

Is your condition due to an accident? Yes _____ No _____ Date of Accident _____

Type of accident: Auto _____ Work/ On Job _____ At home _____ Other _____

Have you ever been in an Auto Accident? Past Yr _____ Past 5 yrs _____ Over 5 yrs _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature _____Date _____

Spouse or Guardian's Signature _____Date _____

Notice to our patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Insurance Cases: On all insurance assignments the deductible must be met in the beginning unless prior arrangements are made.

Any fee for collecting outstanding balances will be the patient's responsibility

Health Questionnaire

Name: _____

List all of your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever been in an industrial injury or any other injury for which you received treatments? When?

Please check the conditions you have or have had:

☐ AIDS	☐ Epilepsy	☐ polio
☐ anemia	☐ hypoglycemia	☐ rheumatic fever
☐ arthritis	☐ multiple sclerosis	☐ tuberculosis
☐ cancer	☐ Parkinson's disease	☐ venereal disease

Family History	Age	Health problems or cause of death
Mother:		
Father:		
Mother's mother:		
Mother's father:		
Father's mother:		
Father's father:		
Brothers:		
Sisters:		
Children:		

Please check □ all present symptoms

CARDIOVASCULAR

- □ general swelling
- □ swelling in legs
- □ swelling in face
- □ chest pain
- □ pounding heart beat
- □ heart "jumps"
- □ rapid heart beat
- □ blue or purple nailbeds
- □ fainting
- □ hypertension

VERTEBROBASILAR

- □ double vision
- □ loss of coordination
- □ irregular muscle movement
- □ ringing in the ears
- □ heart attack
- □ high blood pressure
- □ irregular heart beat
- □ hardening of the arteries
- □ areas of muscle weakness
- □ dizziness with nausea
- □ dizziness without nausea
- □ fainting spells
- □ stroke
- □ diabetes
- □ pain over the heart
- □ cold hands and/or feet
- □ areas of numbness
- □ arthritis of the neck
- □ previous neck or head injury
- □ loss of memory
- □ inability to form words (talk plainly)
- □ periods of blindness in one eyes
- □ areas of abnormal sensations (burning)
- □ blood vessel disease (phlebitis etc.)
- □ check if you smoke
- □ check if any of your family members have had a stroke
- □ check if you are taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD

- □ unusually frequent headache
- □ unusually severe headache
- □ head feels heavy
- □ vertigo
- □ light headedness
- □ loss of smell
- □ loss of taste
- □ loss of balance
- □ dizziness

NECK

- □ pain in neck
- □ neck pain with movement
- □ swelling in neck
- □ stiff neck
- □ pinched nerve in neck
- □ neck feels out of place
- □ muscle spasms in neck
- □ grinding sounds in neck
- □ popping sound in neck
- □ limited neck movement

SHOULDERS

- □ pain in shoulders
- □ pain across shoulders
- □ muscle spasms in shoulders
- □ can't raise arm above shoulder
- □ can't raise arm above head

ARMS & HANDS

- □ pain in upper arm
- □ pain in forearm
- □ sensation of pins and needles
  - □ in arms
  - □ in fingers
- □ pain in hands
- □ pain in fingers
- □ sore joints in fingers
- □ swollen joints in fingers
- □ loss of grip strength
- □ fingers go to sleep
- □ hands cold

MID BACK

- □ mid back pain
- □ pain between shoulder blades
- □ sharp stabbing pain
- □ pain from front to back
- □ pain over kidney area
- □ muscle spasms in mid back
- □ dull ache

LOW BACK

- □ low back pain
- □ muscle spasms in low back
- □ low back feels out of place

HIPS, LEGS & FEET

- □ pain in buttocks
- □ pain down legs
- □ knee pain
- □ pins and needles in legs
- □ leg cramps
- □ numbness in leg
- □ numbness in toes
- □ cold feet
- □ swollen ankles
- □ swollen feet

HEALTH REVIEW

SKIN, HAIR , NAILS

□	eczema	□	dry skin	□	paper thin nails
□	itchy skin	□	oily skin	□	pale skin
□	dry scalp	□	psoriasis	□	nail biting
□	rough, scaly skin	□	bruise easily		

EYES

□	blurring of vision	□	excessive tearing	□	excessive itching
□	double vision	□	lack of tearing	□	pain in eyeball
□	eyes fatigue easily	□	light bothers eyes		

NOSE NASOPHARYNX SINUSES

□	unusual nasal discharge	□	obstruction of nose	□	nasal allergies
□	loss of sense of smell	□	nose bleeds	□	frequent colds
□	pressure over eyes	□	sinusitis	□	voice trauma
□	pressure under eyes				

MOUTH AND THROAT

□	pain of mouth	□	bleeding gums	□	cavities
□	pain of throat	□	abscessed teeth	□	change in voice
□	difficulty swallowing	□	dentures		

RESPIRATORY

□	shortness of breath	□	dry cough
□	can't breathe while lying down	□	productive cough
□	cant's sleep while lying down	□	wheezing

GASTROINTESTINAL

□	poor appetite	□	indigestion	□	constant nibbling
□	change in bowel habits	□	nausea & vomiting	□	diarrhea
□	difficulty in swallowing	□	jaundice	□	constipation
□	can't eat some foods	□	abdominal pain	□	hemorrhoids

GENITOURINARY

Urination is	□	frequent	□	normal	□	infrequent	
the amount is	□	high	□	normal	□	low	
□	need to get up at night to urinate		□	abnormal intensity	□	difficult starting	
□	decreased output		□	pain upon urination	□	dribbling	
□	bloody urine		□	cloudy urine	□	abdominal pain	
□	lack of bladder control						

VENEAREAL DISEASE

□	AIDS	□	syphilis	□	gonorrhea	□	other

WOMEN ONLY

□	painful period	□	vaginal discharge	□	irregular period
□	spotting	□	premenstrual symptom	□	lumps in breast

# of pregnancies _____ # of deliveries _____

SOCIAL HISTORY

□	smoking	□	alcohol use
□	other tobacco use	□	drink coffee or tea

Diet is	□	balanced	□	not balanced
Rest is	□	sufficient	□	not sufficient
Recreation is	□	sufficient	□	not sufficient

My family stress is	□	severe	□	minimal
	□	moderate	□	none

How do you like your work?	□	I like it very much
	□	It's ok
	□	I hate it

My job stress is:	□	severe	□	minimal
	□	moderate	□	none

□	nervousness	□	irritability
□	fatigue	□	depression
□	generally feel run down	□	crave sweets
□	crave salt		

Consent, Release, and Authorization Form

Date: _____ Time: _____ AM/PM

Diagnostic x-rays may be advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness). If x-rays are determined to me necessary I authorized Dr. Hengel to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my condition. (To the best of my knowledge I am not pregnant and diagnostic x-rays are permitted).

Authorization to Release Information

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

Notice of Assignment

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness the assignee. I agree that a photostatic copy of this agreement shall serve as the original. As of this notice I request that the name, Edward A. Hengel, D.C., be included on any payment for my treatment.

Signature _____ Date: _____

Assignment and/or release authorization is granted to :

Affton Lemay Chiropractic Center. L.L.C.

Edward A. Hengel, D.C.

4006 Bayless Avenue

St. Louis, MO 63125

314-631-5550

Affton Lemay Chiropractic Center Financial Policy

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic office. We are not certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office, pay the insurance policy deductible and the patient's percentage or copay as stated in your policy. As a courtesy to our patient's our office will complete any necessary insurance forms at no charges. If your insurance company fails to process the claims after a second submission you will be required to pay for services and seek reimbursement from your insurance company. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible in the event that your insurance company denies payment. We will assist you in verifying your insurance coverage however, it is your responsibility to know the provisions of your particular policy. When all insurance checks have been received, we will refund any overpayment to you.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS Please present your auto insurance forms as soon as possible. If any attorney is handling your case, please notify our insurance personnel right away. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient and do not have major medical or medical payments coverage. We do not accept provider discounts because the liability carrier or medical payments coverage is the primary insurance company all others are secondary. If you suspend or terminate care, any fees and services are due immediately. We will contact your attorney and insurance companies to begin settlement procedures upon release from active care. If your case is not settled within 90 days from your release, we will require you to make partial payments of 20% of your outstanding balance for the next 5 months. At any point settlement is reached, your account is due and payable in full immediately.

ON THE JOB INJURY: Worker's Compensation pays in full for Chiropractic care when approved by your employer. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

** Regardless of which plan you are under, you will be required to pay for all products, durable supplies, orthotics, nutritional supplements etc. at the time they are provided to you.

Note: Your health information will be kept confidential. Any information we collect about you will be kept confidential in our offices. If a claim is submitted to an insurance provider you health information may be shared with the insurance company. The insurance company will keep your information confidential.

Any fee for collecting outstanding balances will be the patient's responsibility

Signature _____ Date _____

PATIENT NAME		
PHONE		
DATE OF BIRTH		
AGE AND SEX		

PRE-PAY OPTIONS

There is a fee for Radiology Interpretation. Enclose one fee per date of films. Below are your payment options.

□ **CASH** □ **CHECK CK#** _____ □ **DR** □ **PT**

Card Holders Name: _____

CC #: _____ - _____ - _____ - _____

EXP DATE: _____

DEAR PATIENT
Your signature on this form gives permission for Radiology Consultants Midwest to read your x-rays. The doctor has all x-rays read by radiologists. Radiologists are doctors who have finished residencies and are trained professionals that specialize in reading x-rays and writing radiology reports.

The doctor has made special arrangements as a cost savings to you as the patient. The radiologists will accept a discounted prepay discount rate. If you do not prepay and they bill you directly the price range is $65.00 to $145.00.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS SERVICE.

AGREEMENT TO PAYMENT TERMS:
THERE WILL BE A FEE CHARGED FOR X-RAY INTERPRETATION. THIS FEE WILL BE PAID TO RADIOLOGY CONSTULTANTS/MIDWEST. I AGREE TO REMIT IN FULL, PRE-PAYMENT FOR THESE SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE, IF I CHOOSE, TO SUBMIT TO ANY INSURANCE CARRIERS OR OTHER PARTIES THAT MAY HAVE RESPONSIBILITY OR LIABILITY FOR THE SERVICES RENDERED.

MEDICARE REGULATIONS DO NOT ALLOW MEDICARE PAYMENT FOR THESE SERVICES.

_____ _____ _____
PATIENT SIGNATURE PARENT/GUARDIAN DATE

A copy of this form can serve as your receipt after payment has cleared. Complete the following information and file with your records.

Date of Service	CPT	Description	Fee
_____	76140	X-ray Consultation and Report	$ _____

DOCTOR COMMENT or QUESTION:

AFFTON LEMAY CHIROPRACTIC
DR. HENGEL

RCM OFFICE USE ONLY

C/S 2 3 5 7 B _____
T/S 1 2 _____
L/S 2 3 4 5 B _____
PELVIS _____
F/S 1 2 _____

_____ _____
_____ _____

RADIOLOGIST 1 2 3

RADIOLOGY CONSULTANTS/MIDWEST
201 ENCHANTED PARKWAY
BALLWIN, MO 63021

(636)256-7779
(636)227-0624 FAX
FED ID # 43-1912520