

Sussex Chiropractic, S.C.

Patient Case History

Confidential Patient Information:

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

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

Address/City/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address Home: \_\_\_\_\_ E-mail Address Work: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Martial Status: M S W D

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's SS Number: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

REFERRED TO OUR OFFICE BY: \_\_\_\_\_

Emergency Contact- Name: \_\_\_\_\_ Phone: \_\_\_\_\_

PURPOSE OF THIS APPOINTMENT: \_\_\_\_\_

Have you seen other doctors for this condition: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_

Have you had any operations: \_\_\_\_\_

If yes, what kind \_\_\_\_\_

Serious Illnesses: \_\_\_\_\_

Are you taking any prescriptions: \_\_\_\_\_ If yes, please name them: \_\_\_\_\_

Have you ever suffered from: Yes or No

- |                        |                               |                               |
|------------------------|-------------------------------|-------------------------------|
| 1. Dizziness _____     | 7. Headaches _____            | 13. Sinus Trouble _____       |
| 2. Backaches _____     | 8. Numbness _____             | 14. Anemia _____              |
| 3. Heart Trouble _____ | 9. Asthma _____               | 15. Rheumatic Fever _____     |
| 4. Diabetes _____      | 10. Neuritis _____            | 16. Cancer _____              |
| 5. Hernia _____        | 11. Digestive Disorders _____ | 17. High Blood Pressure _____ |
| 6. Arthritis _____     | 12. Nervousness _____         |                               |

Please check any and all insurance coverage that may be applicable in this case.

\_\_\_ Major Medical      \_\_\_ Worker's Comp.      \_\_\_ Medicaid

\_\_\_ Medicare      \_\_\_ Auto Accident      \_\_\_ Other

Name of Primary Insurance Company \_\_\_\_\_

Name of Secondary Insurance Company (if any) \_\_\_\_\_

AUTHORIZATION AND RELEASE: I understand that if I am accepted as a patient of Dr. Loftus and Sussex Chiropractic, S.C., I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

PATIENT'S SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_

GUARDIAN'S AUTHORIZED SIGNATURE \_\_\_\_\_