WELCOME

PATIENT INFORMATION

Date ____________________

SS/HIC/Patient ID # ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial

Address ____________________

City ____________________

State ____________ Zip ____________

E-mail ____________________

Sex ☐ M ☐ F Age ____________

Birthdate ____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _______ years

Occupation ____________________

Patient Employer/School ____________________

Employer/School Address ____________________

____

Employer/School Phone (_____) ____________________

Spouse's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

INSURANCE

Who is responsible for this account? ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to
Name of Insurance Company(ies)

Dr.____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________________ ____________________
Date Relationship to Patient

PHONE NUMBERS

Home Phone (______) ____________________

Cell Phone (______) ____________________

Best time and place to reach you ____________________

IN CASE OF EMERGENCY, CONTACT

Name ____________________

Relationship ____________________

Home Phone (______) ____________________

Work Phone (______) ____________________

ACCIDENT INFORMATION

Is 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 ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

____

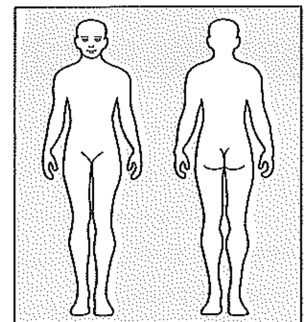
PATIENT CONDITION

Reason for Visit ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____________________

Is it constant or does it come and go? ____________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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chiropractic

Bringing Out The Best In You!

Accident/Injury Report

Patient__________________________________Date________________

An accident or trauma **of any kind can cause you to have** subluxations which **can affect your physical and emotional health.** Every accident victim needs a checkup by a doctor of chiropractic.

Please indicate the type of accident you were involved in:

○ work ○ sports ○ auto ○ personal injury ○ other __________

Date of accident__________ Time________ Location____________________

Please explain how you were injured. Be as detailed as possible. If it was an auto accident, please mention the speed of the vehicles, where your car was hit, the damage that was done, the weather conditions and your state of mind/health at the time of the accident. Let us know if you need more paper.

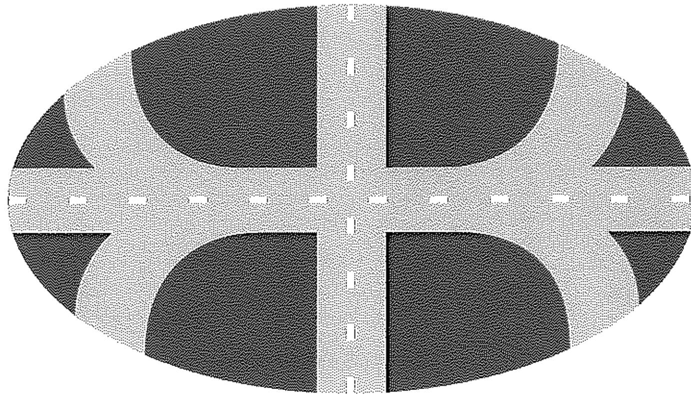
____

____

____

____

Please illustrate the accident with all involved vehicles (if applicable) below.



I was ○ driving ○ a passenger in a ________________________ (type of vehicle) on a ______________ (i.e., street or highway). The other vehicle was a ____________________ (type of vehicle).

I was
○ in front, left ○ in front, right ○ in back, left ○ in back, right
○ turned to the left ○ turned to the right ○ facing front ○ facing back
○ wearing a seat belt ○ air bag deployed ○ struck steering wheel ○ struck headrest
○ struck windshield ○ other ____________________

Were other people in the car? ○ no ○ yes

If yes, were they hurt? ○ no ○ yes

This form continues on the reverse side.

Sendroff Chiropractic Center

2810 U.S. Hwy 70 SE, Hickory, NC 28602
Phone (828) 328-3305 Fax (828) 328-9151

We MUST have this information by the second visit!

Please fill out the information correctly below so that we can file the insurance properly.

PATIENT NAME:____

DATE OF ACCIDENT:______________________________________

INSURANCE COMPANY AT FAULT:____________________________

____

PHONE NUMBER: ____

***BODILY INJURY CLAIM #:**

____

Medical Payments Information

Do you have any Medical Payment on your automobile policy you would like to file?

Yes__________ No________

If yes, please fill in the information below.

NAME OF INSURANCE COMPANY:______________________________

NAME OF MED-PAY ADJUSTER:_______________________________

PHONE NUMBER:____

***MED-PAY CLAIM #:**_____________________________________

- Medical Payments is health insurance coverage you have through your own personal automobile policy. You have already paid it in full through your premium. Filing it will not cause your insurance to increase or decrease. To inquire about it, you can contact your agent to discuss whether or not you have Medical Payment coverage.

RECORDS RELEASE, ASSIGNMENT OF BENEFITS, LIMITED POWER OF ATTORNEY FOR THIS CASE AND PAYMENT AGREEMENT

FOR VALUE RECEIVED, I HEREBY ASSIGN TO DR. SENDROFF, HEREINAFTER REFERRED TO AS DOCTOR, TO THE EXTENT OF MY BILL FOR HEALTH CARE SERVICES, ANY AND ALL CLAIMS WHICH I MAY HAVE.

(A) FOR BENEFITS PROVIDED UNDER ANY POLICY OF INSURANCE OR OTHER HEALTH CARE PLAN INCLUDING BUT NOT LIMITED TO THE FOLLOWING DESCRIBED POLICIES.

____

(B) AGAINST ANY OTHER PARTY WHOSE NEGLIGENCE MAY HAVE CAUSED MY INJURIES OR WHO MAY BE LEGALLY RESPONSIBLE FOR MY INJURIES, ILLNESS, OR HEALTH CASE COSTS.

I FURTHER HEREBY ASSIGN TO DOCTOR A LIEN IN THE AMOUNT OF MY BILL FOR HEALTH CARE SERVICES AGAINST THE PROCEEDS OF ANY INSURANCE POLICY, OR HEALTH CARE PLAN, AND AGAINST ANY CLAIM WHICH I MAY HAVE AGAINST ANY OTHER PARTY WHOSE NEGLIGENCE MAY HAVE CAUSED MY INJURIES, OR WHO MAY BE LEGALLY RESPONSIBLE FOR MY INJURIES, ILLNESS OR HEALTH CARE COSTS.

I HEREBY DIRECT PAYMENT BE MADE DIRECTLY TO THE DOCTOR. I HEREBY APPOINT DOCTOR AS MY TRUE AND LAWFUL ATTORNEY, IRREVOCABLE, AND WITH POWER OF SUBSTITUTION FOR ME AND IN MY NAME, TO ASK, DEMAND, SUE FOR, COLLECT, ENDORSE, SIGN, AND RECEIVE ANY SUCH INSURANCE OR OTHER BENEFITS OR CLAIMS AGAINST OTHER PARTIES FOR MY INJURIES. ALTHOUGH DOCTOR SHALL BE GRANTED SUCH POWERS CONTAINED HEREIN, DOCTOR IS NOT OBLIGATED OR COMPELLED TO EXERCISE SUCH POWERS BUT MAY DO SO AT DOCTOR'S DISCRETION. I AGREE TO COOPERATE WITH DOCTOR IN COLLECTING ANY SUCH AMOUNTS, INCLUDING APPEARING IN COURT IF NECESSARY. DOCTOR IS FURTHER EMPOWERED TO PLAN ANY AND ALL INFORMATION AND DOCUMENTS PERTAINING TO MY POLICIES INCLUDING A COPY OF SUCH POLICY AND ANY INFORMATION OR SUPPORTING DOCUMENTATION CONCERNING OR TOUCHING UPON THE HANDLING, CALCULATION, PROCESSING, OR PAYMENT OF ANY CLAIM.

IN THE EVENT THAT I RECEIVE DIRECTLY ANY CHECK, DRAFT, OR OTHER BENEFITS SUBJECT TO THIS ASSIGNMENT AT A TIME WHEN THERE IS STILL A BALANCE DUE DOCTOR, I AGREE TO DELIVER SUCH CHECK, DRAFT, OR BENEFIT TO DOCTOR IMMEDIATELY UPON RECEIPT, AND THE PROCEEDS THEREOF SHALL BE APPLIED TO MY BILL.

I HEREBY AUTHORIZE DOCTOR TO RELEASE AND TO PERMIT THE EXAMINATION OR COPYING OF ANY OF MY MEDICAL RECORDS, X-RAYS, LABORATORY REPORTS AND THE RESULTS OF ALL TESTS OF ANY TYPE OR CHARACTER TO SUCH PERSONS AS DOCTOR DEEMS APPROPRIATE.

IN THE EVENT THAT PROVISION OF THIS AGREEMENT IS DETERMINED TO BE INVALID OR UNENFORCEABLE, ALL OTHER PROVISIONS OF THIS AGREEMENT SHALL REMAIN ENFORCEABLE.

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN THE DAY AND YEAR SET FORTH BELOW.

____ ____________________

SIGNATURE (PATIENT OR GUARDIAN IF PATIENT IS MINOR) DATE