WELCOME

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information

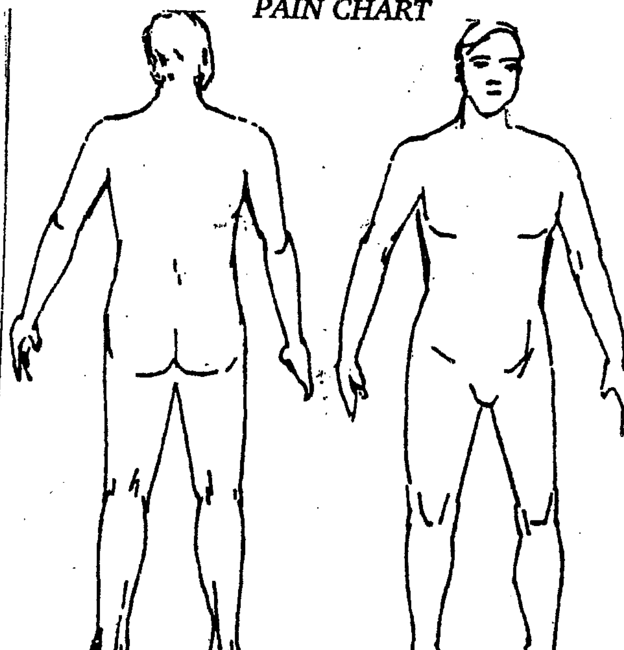
Name ______________________________ Date ____________ Age ________
S/S ________-________-________ How would you like to be addressed in this office? ____________________
Address ______________________________ City ____________________ State ______ Zip __________
Sex: ☐ Female ☐ Male
Birth Date __________________ Home Phone # ____________________ Work Phone # ______________
Are You: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated
Spouse's or Parent's Name ______________________________________
Whom may we thank for referring you to us? ______________________________
Person to Contact in Case of Emergency? ______________________________

Email Address: ______________________________

Symptoms

Reason for Visit ______________________________
When did you first notice the symptoms? ______________________________
Is this condition getting progressively worse? ______________________________
Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other
Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
Rate the Severity of your Pain. (1, mild pain or discomfort, to 10, severe pain) 1 2 3 4 5 6 7 8 9 10
What Treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy
☐ Other ______________
Name of doctor(s) who have treated you for your condition: ______________________________
Have you ever had an X-ray / MRI in the past? ☐ Yes ☐ No
If yes, what area? ______________________________

PAIN CHART



Please make an "x" where the pain is.

Health History
Check only those conditions which are applicable:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Suicide Attempt
- ☐ Tumors, Growths
- ☐ Venereal Disease
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Thyroid Problems
- ☐ Typhoid Fever
- ☐ Whooping Cough
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Tonsilitis
- ☐ Ulcers
- ☐ Other: ______________________________
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vaginal Infection

Date of last Physical? ____________________

(Women) Are You Pregnant? ☐ *Yes* ☐ *No* *Nursing?* ☐ *Yes* ☐ *No* *Taking Birth Control Pills?* ☐ *Yes* ☐ *No*

List any types of surgeries which you have had and the dates which they occurred:

____

____

Please List All Medications you are currently taking: ______________________________

Allergies: ____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ *None* ☐ *Moderate* ☐ *Heavy*

What do your daily work habits include? (Ex. Sitting, standing, light labor, heavy labor, computer work)

____

What vitamins do you currently take? ______________________________

What kind of other nutritional supplements do you take (if any)? ______________________________

Do you smoke? ☐ *Yes* ☐ *No* *If yes, How much per day?* ______________________________

How much liquor do you consume on a weekly basis? ______________________________

How much coffee or caffeinated beverages do you consume on a daily basis? ______________________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature ______________________________ ***Date*** ____________________

Insurance Information

Who is responsible for you bill? You and: ☐ *Spouse* ☐ *Personal Health Ins.* ☐ *Medicare* ☐ *Medicaid*

Request For Payment of Benefits to Provider of Care:

I hereby authorize____
Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: Dr. Andrew L. Kemp, D. C., the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature____

Medicare Patients Only:

Explanation of Medicare Benefits

MEDICARE DOES NOT COVER THE COST OF X-RAYS. The use of modalities, therapy, supports, supplements, examinations, or various additional services offered in this office are also not covered. **The only service covered by Medicare is manual manipulation of the spine (chiropractic adjustment).**

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

Patient's Signature____

To All Insurance Patients:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I Understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature____

Authorization to Release Medical Information:

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature: ____

X-ray/Medical Records Release:

I have requested the release of records of

____

Which are parts of the records at

____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to: Dr. Andrew L. Kemp, D.C.

1310 Seven Springs Blvd.
New Port Richey, FL 34655
Office: (727) 372-9500
Fax: (727) 372-1268

Patient's Signature

____

Patient Pregnancy Disclaimer:

At the present time:

________ I am sure that I am not pregnant.

________ It is possible that I could be pregnant.

________ I am pregnant.

Patient's Signature________________________________Date:____________