New Patient Registration

So that we may best serve your healthcare needs, please complete the following information as accurately as possible. Thank you!

Today's Date _____/_____/_____

Legal Name _____

First name you would like to be called _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email Address _____

Gender: Male Female **Marital Status**: Single Married Separated Divorced Widowed

Date of Birth _____ **SS#** _____ - ____ - _____ **Age** _____

Emergency Contact: _____ ***Relationship**: _____

Phone (_____) _____

Check below how you would like to receive appointment reminders:
□ Text message □ Phone (home/cell) □ Email

What sources did you first utilize to choose our office? Check all that apply:

1. Referred by: _____ 2. Internet ___3. Called Insurance ___ 4. Angie's List ___

Employer _____ **Occupation** _____

Do you have health insurance you wish for us to file? Yes / No

Have you seen another chiropractor this year? Yes / No

Name of Insurance policy holder/subscriber _____**DOB**: _____

Relationship to subscriber _____ **Subscribers employer** _____

Do you have a secondary insurance? Yes _____ No_____

_____ Date _____/_____/_____
Signature of Patient (or Guardian if under 18)

Print Name _____ Date _____/_____/_____

Welcome to West Chester Acupuncture and Chiropractic
Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.
7665 Monarch Court, Suite 110, West Chester, OH 45069 ● 513-777-9428

MEDICAL HISTORY

Patient Name

Main Complaints 1 2. 3

General

☐ Poor Appetite ☐ Heavy appetite ☐ Change in appetite: (how)
☐ Poor Sleep ☐ Heavy sleep ☐ Insomnia ☐ Hours of sleep:
☐ Waking at night ☐ Trouble waking ☐Trouble going back to sleep ☐ Hours of sleep
☐ When to bed: ☐ When to wake ☐ Dreams ☐ Fatigue
☐ Tremors ☐ Vertigo ☐ Cold Hands ☐ Cold feet
☐Cold back ☐ Cold abdomen ☐ Fevers ☐ Chills
☐Night Sweats ☐ Sweat easily ☐ Cravings ☐ Localized weakness
☐ Poor coordination ☐ Sudden energy drop ☐ Sudden increase in energy ☐ Peculiar tastes/smells
☐ Strong thirst ☐ Bleeding/bruising easily ☐ Best time of day ☐ Worst time of day

Skin & Hair

☐ Dandruff ☐ Eczema ☐ Hives ☐ Itching
☐ Pimples ☐ Purpura ☐ Rashes ☐ Ulcerations
☐ Changes in hair/skin: ☐ Other hair or skin problems:

Head, Eyes, Ears, Nose & Throat

☐ Dizziness ☐ Concussions ☐ Earaches ☐ Ringing in ears
☐ Poor hearing ☐ Facial pain ☐ Facial paralysis ☐ Eye strain
☐ Eye pain ☐ Poor vision ☐ Blurry vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Spots in eyes ☐ Nosebleeds
☐ Sinus problems ☐ Mucus ☐ Dry throat ☐ Dry mouth
☐ Copious saliva ☐ Teeth problems ☐ Gum problems ☐ Jaw clicks
☐ Grinding teeth ☐ Sores on lips or tongue ☐ Recurrent sore throats ☐ Migraines
☐ Headaches ☐ other head or neck:

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other:

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MEDICAL HISTORY

Patient Name_____

Respiratory

☐ Cough
☐ Bronchitis
☐ Other lung problems: _____
☐Coughing up blood
☐ Pneumonia
☐ Production of phlegm
☐ Tight chest
☐Asthma
☐ Difficulty when laying down

Gastrointestinal

☐Nausea
☐ Belching
☐ Black stools
☐Hemorrhoids
☐ Vomiting
☐ Constipation
☐ Sensitive abdomen
☐ Laxative use
☐Diarrhea
☐Bad Breath
☐Pain or cramps
☐ Undigested food
☐ Gas
☐ Rectal pain
☐ Bloody stools, odor

Genitourinary

☐ Pain with urination
☐ Unable to hold urine
☐ Urinary tract infection
☐Blood in urine
☐Unable to complete
☐ Kidney stones
☐Cloudy urine
☐ Dribbling
☐ Prostate problems
☐ Urgency to urinate
☐STD
☐ Wake to urinate

Gynecology Pregnancy

Age at first menses_____
Last PAP_____
Last Menses,_____
D Birth Control
Pregnancies#._____
Births#-_____
Miscarriages
Premature births._____
☐ Irregular Periods
☐ Painful periods
☐ Vaginal Discharge
☐ Changes to body/psyche prior to menstruation
☐ Menopause
☐ Clots
☐ Breast lumps

Neuropsychological

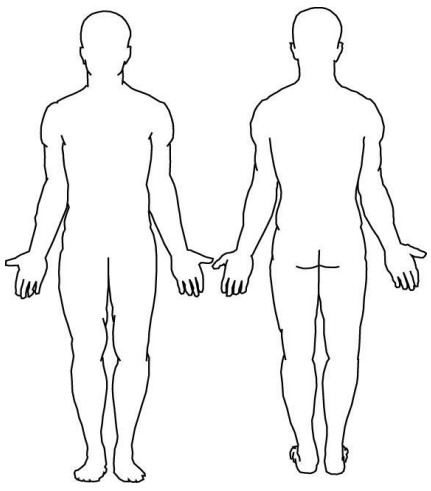
☐ Depression
☐ Treated for emotional problems
☐Other: _____
☐Areas of numbness
☐Anxiety
☐Poor memory
☐ Bad temper
☐ Considered/Attempted suicide
☐ Concussion
☐ Easily stressed
☐Seizures

Musculoskeletal

☐ Neck pain
☐ Limb pain
☐ Back pain
☐ Muscle pain
☐ Joint pain
☐ Sharp quality
☐ Burning quality
☐ Better/worse wlth heat
☐ Better/worse with cold
☐ Better/worse with movement
☐ Better/worse with pressure
Fixed location
☐ Dull quality
☐ Stabbing quality

Put a mark on the scale to indicate you present level of pain:
No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst possible Discomfort

Mark location of pain or injury:



MEDICAL HISTORY

Patient Name,_____

Significant Illnesses (list date of diagnosis)

o Cancer ☐ Diabetes ☐ High Blood Pressure Other:_____

☐ Hepatitis ☐ Rheumatic Fever ☐ Thyroid Disease _____

D HIV D Heart Disease ☐ Seizures _____

☐ Surgeries (type & date):

_____

_____

o Significant Trauma (type and date):

_____

_____

Miscellaneous Information:

Birth History (prolonged labor, premature, forceps delivery, etc.).:_____

Allergies (drugs, chemicals, food, etc.):_____

_____

_____

Medication (name and dosage, include vitamins and herbs): _____

_____

_____

Occupational Stresses (chemical, physical, psychological):._____

_____

_____

Exercise (type and frequency).:_____

Average daily diet (list morning, afternoon and evening).:_____

_____

_____

Family History

☐ Cancer o Diabetes ☐ High Blood Pressure ☐ Allergies

☐ Stroke o Seizures ☐ Asthma ☐ Heart disease

☐ Alcoholism ☐ Multiple sclerosis Other: _____

_____

Notes (please add anything of note)

_____

_____

_____

_____

_____

Financial Policy

Payments/deductibles and/or co-payments are due at the time of service. A payment of $60.00 **OR** your Copay (if clearly marked on your insurance card) will be required at the time of service until we have verified your insurance. A current insurance card must be presented at the time service is provided. If charges are filed incorrectly due to outdated information, the complete balance then becomes your responsibility. Many of our families have Health Savings Accounts (HSA), or Health Reimbursement Accounts (HRA). You will be expected to pay at the time of service until your deductible is met. We accept cash, check, or any major credit card.

It is your responsibility to know the details of your insurance plan.

Please check which one of the following applies:

_____ **INSURANCE**
(□ Check here for VA patients with active authorization)
If your insurance is a high deductible plan, the office will collect in anticipation of your finalized claim. Once your Deductible has been met, your co-insurance will be collected each visit.

_____ **MEDICARE/Advantage Plans (See ABN form)**

_____ **MEDICAID (Molina/Caresource/Ohio Job and Family Services)**
If eligible, you must bring a current Medicaid card on the first visits and at the beginning of each month Thereafter when receiving treatment.

_____ **WORKER'S COMPENSATION**
It is your responsibility to notify your employer and the doctor if you are seeking treatment from an injury sustained while on-the-job. This type of injury is classified as an industrial injury and will be billed accordingly. If the injury neglects to meet the requirements of the Industrial Commission and they will not pay, you are responsible for all charges incurred in this office. If you have an established claim, please notify the receptionist that you need to sign a transfer of physician form.

_____ **PERSONAL INJURY**
We do not accept third-party payer. We do not bill the at-fault. Dr. Hilbert/Dr. Young recommends that you immediately file a claim with your automobile insurance. We bill med-pay first. When all med-pay funds have been used we will bill your health insurance. At the time of service you will be responsible for the deductibles, co-pays, etc. If you do not have health insurance or med pay, then you are responsible to pay as treatment is received on the day of each visit by cash, check, or credit card. Each case is unique so please do not hesitate to ask the receptionist. Ultimately, you are responsible for all charges incurred for treatment in our office.

_____ **NO INSURANCE COVERAGE**
Patient pays all fees on the day services are rendered by cash, check, or all major credit cards.

I hereby authorize any holder of medical information to release to my insurance company or intermediaries any Information needed to process a claim for payment. I request that payment be made to Julie B. Hilbert, DC, Inc. for Any charges or services rendered to me by Julie B Hilbert, DC, FIAMA, Dipl.Ac. And/or Burton T Young, DC, FIAMA, Dipl.Ac. I understand I am financially responsible for any balance not covered. I agree to the terms in the Financial policy as stated above for the acupuncture and/or chiropractic care rendered to me by either of doctors Mentioned above. A late fee of $25 per month will be added to the balance, beginning at 90 days after service is rendered. Balances over 90 days past due will be forwarded to our collection agency.

_____ _____
Signature of Patient (Parent/Guardian) Date

_____ _____
Print Name of Patient (Parent/Guardian) Date

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Terms of Acceptance

Patient Name: _____ Date: _____

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Dr.Julie B. Hilbert/Dr. Burton T. Young's office, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Consent to medical records submission:

Periodically medical records are requested by your insurance company and upon that request I agree to have all visit information sent.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____ No one □

Others: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes □ No □

Appointment Cancellation Policy:

Please provide 24 hour notice in the event that you need to reschedule.This will allow us the opportunity to provide care to another patient. A message can be left on our voicemail if we are unable to answer.
Repeated missed appointments without notice may result in termination of the physician/patient relationship.
As a courtesy, we make reminder calls, texts, e-mails one to two days in advance. If a reminder call or message is not received the cancellation policy remains in effect.

Acknowledgement

□ By subscribing my name below, I acknowledge my understanding and agreement to the notice of privacy practices (HIPAA effective as of 9/23/2013). I DO NOT want a copy of my HIPAA laws at this time.

□ By subscribing my name below, I acknowledge my understanding and agreement to the notice of privacy practices (HIPAA effective as of 9/23/2013). I have requested a copy of my HIPAA laws at this time.

Print Name: _____

Signature: _____ Date: _____