Omdalen Chiropractic Clinic, P.C.

Today's Date:_____

Patient Information

First name: _____ MI: _____ Last name:_____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Social Security Number: _____

Email: _____ Gender: M / F Marital Status: M S D W

Home Phone: _____ Cell phone: _____

Employer: _____ Employer Phone: _____

Emergency Contact Information

Full Name: _____ Relationship: _____

Phone Number(s): _____

Previous Care

Date of Last Physical Exam: _____ Have you received any previous chiropractic care? Yes No

Other doctors seen for this condition: _____

List medications and vitamins you are taking: _____

List Surgeries, Date, Type, and Reason: _____

Major Injuries/Traumas: _____

Major Hospitalizations: _____

List relevant major health problems of immediate relatives: _____

Insurance/Financial Information

Have your card with you? We will make a copy.

Type: Cash Private Health Insurance Medicare Workman's Comp Accident ND Medicaid

Insurance Name and Address: _____

Policy Number: _____ Group Number: _____

Policy Holder Name (if other than self): _____

Who is responsible for payment? Self / Other (name and relationship) _____

Responsible party's address (if other than self): _____

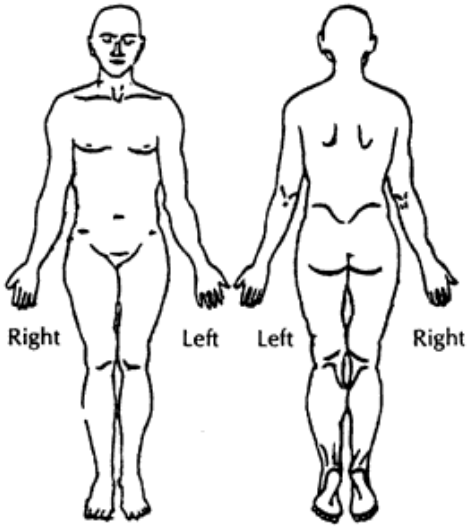
Responsible party's phone number: _____

It is policy to pay when services are rendered unless otherwise arranged.

Omdalen Chiropractic Clinic, P.C.

HEALTH QUESTIONAIRE

Please mark your areas of pain on figures below.



Describe Major Complaint(s): _____

_____

_____

When and how did it begin? _____

_____

_____

List activities that cause pain in region of complaint (i.e. walking, sitting, bending): _____

_____

List activities that relieve pain in region of complaint (i.e. icing, stretching): _____

_____

Write an X for current and P for past for conditions listed below.

Musculo-Skeletal System

__ Low back problems
__ Pain between shoulders
__ Neck problems
__ Arm problems
__ Leg problems
__ Swollen joints
__ Foot/Ankle problems
__ Painful joints
__ Hand/Wrist problems
__ Hip problems
__ Sore muscles
__ Shoulder problems
__ Weak muscles
__ Ruptures
__ Broken bones
__ Subluxations
__ Knee problems

Genito-Urinary System

__ Bladder trouble
__ Excessive urination
__ Scanty
__ Painful urination
__ Bladder/Kidney infection

Gastro-Intestinal System

__ Poor appetite
__ Excessive hunger
__ Crave sweets
__ Difficulty chewing
__ Difficulty swallowing
__ Excessive thirst
__ Nausea
__ Belching
__ Vomiting
__ Overweight
__ Indigestion
__ Abdominal pain
__ Diarrhea
__ Gas
__ Constipation
__ Bloody stools
__ Hemorrhoids
__ Liver trouble
__ Gall bladder problems
__ Underweight

Female Only

__ Vaginal discharge
__ Vaginal bleeding
__ Vaginal pain
__ Breast pain
__ Lumps on breast
__ Menstrual cramps
__ Hot flashes
__ Irregular periods

Nervous System

__ Numbness/tingling
__ Loss of feeling
__ Fatigue
__ Paralysis
__ Pins & Needles
__ Dizziness
__ Fainting
__ Difficulty sleeping
__ Irritability/tension
__ Headaches
__ Light bothers eyes
__ Muscle jerking
__ Loss of balance
__ Convulsions
__ Forgetfulness
__ Cold hands/feet
__ Confusion
__ Depression

Cardio-Vascular-Respiratory

__ Chest pain
__ Pain over heart
__ Difficult breathing
__ Asthma/Short of breath
__ Persistent cough
__ Coughing phlegm
__ Blood pressure problems
__ Heart problems
__ Lung problems
__ Varicose veins
__ Hiatal hernia
__ Rapid heartbeat

Eye, Ear, Nose, & Throat

__ Eye strain
__ Eye inflammation
__ Vision problems
__ Blurring of vision
__ Wears glasses/contacts
__ Ear pain
__ Ear noises
__ Ear discharge
__ Hearing loss
__ Nose pain
__ Nose bleeding
__ Difficulty breathing through nose
__ Sore gums
__ Wear dentures
__ Dental problems
__ Sore mouth
__ Sore throat
__ Hoarseness
__ Difficult speech
__ Tonsillitis
__ Thyroid problems
__ Allergies
__ Sinus trouble

Omdalen Chiropractic Clinic, P.C.

Patient Payment Requirements

Dear Patient,

Thank you for choosing us as your health care provider. The following is a description of our financial policy:
Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, and Discover. We reserve the right to collect before services are rendered.

I understand that all charges are my responsibility whether the insurance company pays or not. Not all services are a covered benefit. Benefits may vary on different insurance plans. It is my responsibility to verify my insurance coverage. Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.

If coverage for a particular service and or supply is denied by your insurance company, we may require you to follow up with your insurance and/or pay the balance due. Unless you are insured by Medicare or an insurance group which our doctor is a participating member, or double- insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered. Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

By signing this form, I agree to the terms and conditions outlined in the financial policy stated above.

_____

Patient's Name (printed)

_____ _____

Patient or Authorized Representative Signature Date

Receipt of Notice of Privacy Practices

My signature on this form acknowledges that I have received a copy of the Omdalen Chiropractic Clinic, P.C. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Omdalen Chiropractic Clinic, P.C. and my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient Name: _____ Date of Birth: _____

_____ _____

Patient or Authorized Representative Signature Date