SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.

Dr. Timothy A. Swank, D.C., C.C.S.P.

Today's Date: ___________

Patient Information

Name ____ DOB________________________

Address ____ SS#__________________________

City __________________ State________ Zip____________ Email_________________________

Home Phone ________________ Cell Phone _________________ Work Phone _______________

Sex M F Age_________ Marital Status S M W S D # Children 0 1 2 3 4 5

Patient Employed by _________________________________ Occupation____________________

Employers Address____________________________________ Phone________________________

Notify in case of emergency ____________________________ Phone ________________________

Who is your M.D _____________________________________ Phone ________________________

Whom may we thank for referring you to our office? _______________________________

Primary Health Insurance

Name of Ins: __________________________
Address: _____________________________
Policy #: _____________________________
Group #: _____________________________
Phone #: _____________________________
Employer: ____________________________
Ins. Effective Date: ____________________

Spouse's Insurance

Name of Ins: ___________________________
Address: _______________________________
Policy #: _______________________________
Group #: _______________________________
Phone #: _______________________________
Employer: ______________________________
Spouse's D.O.B.: ________________________

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Chiropractic 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 Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services received by me, will be immediately due and payable.

Patients Signature: _________________________________ Date: ______________________

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.
Timothy A. Swank, D.C., C.C.S.P.

Name: ___________________________________

Today's Date: __________Case #   __________

Pre-consultation **Doctor's Notes**

Have you ever been under chiropractic care before?   Yes   No
If yes, when and where? ______________________________________

Your reason for this visit: _____________________________________

When did the symptoms begin (date)? __________________________
Is this related to an accident? _________________________________
How did the accident occur? ___________________________________
Other doctors seen for this condition: ____________________________

Please describe your pain and its location: _______________________
____

Does the pain radiate into other areas? Yes   No
If yes, please list other areas: ___________________________________
What makes your condition better? ____________________________
What makes your condition worse? _____________________________
Have you had similar conditions in the past? _____________________

Activities or movements that you find difficult/painful to perform (circle):
Sitting   Walking   Bending   Lying   Lifting

Type of pain (circle all that apply): Sharp   Dull   Throbbing   Aching   Burning
Tingling   Numbness   Cramping   Stiffness   Swelling   Other __________

Is pain interfering with: Work   Sleep   Daily Routine   Recreation

Health History

Please list any medication (including pain killers) you are taking:________
____

Please list any serious injuries (falls, head injuries, broken bones, dislocations, surgeries, other) ____

Women: Are you pregnant?   Y N   How far along? _______   Nursing Y N

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Medical Conditions

Circle whether you have had or currently have any of the following medical conditions:

Heart Attack/Stroke	Arthritis	Severe/Frequent Headaches
Congenital Heart Defect	Frequent Neck Pain	Diabetes/Tuberculosis
Alcohol/Drug Abuse	Jaw Pain	Dizziness
Anemia	Wrist Pain	Emphysema/Glaucoma
Shingles	Shoulder Pain	Kidney Problems
Psychiatric Problems	Arm Pain	Artificial Bones/Joints
Difficulty Breathing	Leg Pain	Cancer
Hepatitis	Lower Back Problems	HIV Positive/AIDS
Food Allergies	Severe/Frequent Earaches	Ulcer/Colitis
Gout	Ringing in Ears	Fainting/Seizures/Epilepsy

Personal Habits

Alcohol	Heavy	Moderate	Light	None
Coffee	Heavy	Moderate	Light	None
Tobacco	Heavy	Moderate	Light	None
Drugs	Heavy	Moderate	Light	None
Exercise	Heavy	Moderate	Light	None
Sleep	Heavy	Moderate	Light	None
Appetite	Heavy	Moderate	Light	None

Consent of Professional Services and Release of Information

I authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examinations, X-ray studies, laboratory procedures, chiropractic care or any other services that he/she deems necessary in my case: and I further authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or employers.

Patients Signature: ____ Date: _________________

Signature of Parent or Guardian: ________________________________ Date__________________

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.
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Name: ________________________________

Today's Date: ______________Case #_______

Family Health History

Many health problems are hereditary in nature and may be handed down generation after generation. Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

Condition	Father Age ___	Mother Age ___	Spouse Age ___	Brothers Age ___	Sisters Age ___	Children Age ___
Arthritis	____	____	____	____	____	____
Asthma – Hay Fever	____	____	____	____	____	____
Back Trouble	____	____	____	____	____	____
Bursitis	____	____	____	____	____	____
Cancer	____	____	____	____	____	____
Constipation	____	____	____	____	____	____
Diabetes	____	____	____	____	____	____
Disc Problems	____	____	____	____	____	____
Emphysema	____	____	____	____	____	____
Epilepsy	____	____	____	____	____	____
Headaches	____	____	____	____	____	____
Heart Trouble	____	____	____	____	____	____
High Blood Pressure	____	____	____	____	____	____
Insomnia	____	____	____	____	____	____
Kidney Trouble	____	____	____	____	____	____
Liver Trouble	____	____	____	____	____	____
Migraine	____	____	____	____	____	____
Nervousness	____	____	____	____	____	____
Neuralgia	____	____	____	____	____	____
Pinched Nerve	____	____	____	____	____	____
Scoliosis	____	____	____	____	____	____
Sinus Trouble	____	____	____	____	____	____
Stomach Trouble	____	____	____	____	____	____
Other:						
_______________	____	____	____	____	____	____
_______________	____	____	____	____	____	____

If any of the above family members are deceased, please list their age at death and cause: _______________

____

____

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ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefit allowable, and payable under my current insurance policy as payment toward the total charges for my professional services rendered in this office.

A photocopy of this assignment shall be considered as effective and valid as the original

RELEASE OF INFORMATION

I authorize this office known as Swank Chiropractic Center, P.A. to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case and hereby forever release Swank Chiropractic Center, P.A., its agents and employees of any consequence thereof.

RELEASE OF MEDICAL RECORDS

You are hereby authorized and instructed to release to Timothy A. Swank, D.C., Swank Chiropractic Center, P.A., 3731 NW Cary Parkway, Suite 101, Cary, NC 27512 all information/records concerning treatment and/or involvement in the care of my health.

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges to Swank Chiropractic Center, P.A. including my insurance deductible, co-payment, and any services rejected by my insurance company or any other entity responsible for payment.

REFERRALS/AUTHORIZATIONS

I agree to pay for all services when a referral from my primary care physician was not received prior to being seen, or authorization from my insurance company was not obtained at the time of my visit.

AKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Swank Chiropractic Center, P.A. Financial and Consent Policies and I fully understand and agree to each item listed.

I have read, understand, and accept the items listed above.

______________________________________ ______________________________

(patient/guardian signature) (date)