

Personal Information

Date

Name: _____ Nickname: _____

Birthdate: ___/___/___ Age: ___ Sex: M___ F___ Martial Status: S___ M___ W___ D___

Phone: (H) _____ (W) _____ (Cell) _____ (E-Mail) _____

Address: _____ Apt. # _____

City: _____ State _____ Zip _____

Employer: _____ Position: _____

Spouse: _____ Spouse Birthdate: ___/___/___ Spouse employer _____

Children (Name & Ages): _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Did she/he refer you? Yes___ No___

How did you hear about our office? _____

Insurance company name: _____ Insured's date of birth: ___/___/___

Insured's employer: _____ Insured's SS # _____

Assignment of Insurance Benefits:

I assign the payment of benefits due to me under my insurance policy with my carrier, and direct my insurance carrier to pay for all services rendered directly to Dunn Wellness Center.

Release of Medical Information to Insurance Carrier:

I give permission to Dunn Wellness Center to release all medical information files in relation to my history and treatments to my insurance carrier in order to facilitate processing of insurance claims.

Informed Consent Agreement:

If I do not understand the necessity for or the risk of any therapy or manipulative procedure used in my care, I may request an explanation before performed so that I may give informed consent or objection.

Consent to treat a Minor: (if applicable)

I hereby authorize Dr. Dunn, Dr. Banister, Dr. Gordon, Dr. Kampfe and their assistants to administer the medically necessary chiropractic care and therapy, as they deem necessary, and without my presence when necessary. to the above named patient, my _____ (relationship of minor)

I Sign here for consent to treat my minor : _____

****All of the above and following confidential health information has been read and is completed as true by the below signed individual who is responsible for the answering of these statements and the balance of payments on these accounts:**

Patient/Guardian/Parent Signature: _____ Today's date: _____

Present Complaint**Date**

1. What is your major complaint? _____
2. What caused this problem? _____
3. When did your major complaint start? _____
4. Describe the pain: Sharp____ Dull____ Numbness____ Tingling____ Aching____ Itchy____
Burning____ Stabbing____ Other_____
5. How frequent is the condition? Constant____ Intermittent____ Night Only____ Day Only _____
6. How long does it last? All Day____ Few Hours____ Minutes____ Seconds _____
7. What makes the problem worse? Standing____ Sitting____ Lying____ Bending____
Breathing____ Twisting____ Lifting____ Sleeping____ Other_____
8. Is there anything you can do to relieve the problem? Yes__ No__
If yes, please describe: _____
9. Has any doctor recently treated you for this condition? Yes__ No__ In the past? Yes__ No__
Doctor: _____ When: _____
Any: X-rays____ MRI____ Medication____ Injections: _____ Other: _____
Results: None____ Fair____ Good _____ Worse____ Other: _____
10. Is this a recurrence? Yes__ No__ If yes, when did you first notice the problem?_____
11. Are there any other conditions or symptoms you have that may be related to your major symptom?
Yes No If yes, describe_____
12. List medications taken within the last 7 days: _____
13. Last blood work date:_____ Physician Ordering:_____
14. List ALL allergies: _____
15. Have you had any chiropractic or muscle therapy for this condition in the past? Yes__ No__
16. Did you find your prior treatments and experiences helpful? Yes__ No__
Doctor: _____ Treated From: _____ To: _____
What conditions were treated?_____
17. Have you had Acupuncture treatments, Neuromuscular therapy, Herbal or Vitamin therapies ever?
If yes, please comment_____
18. Any changes in your special senses lately? Circle the sense(s) in which you have noticed a change.
Smell Taste Touch Hearing Vision Balance Equilibrium
19. Has your thyroid gland been tested in past year? No__ Yes__ date of last test?_____

Patient's Name:_____**Date:**_____

Dunn Wellness Center

System Review: (Please check all which have applied to you in the past year).

- | | |
|---|--|
| <input type="checkbox"/> Recurring headaches/migraine
<input type="checkbox"/> Dizziness/loss of balance/fainting
<input type="checkbox"/> Eye Pain/temple pain/face pain
<input type="checkbox"/> Jaw pain/TMJ problems/swallowing
<input type="checkbox"/> Forgetfulness/confusion/disorientation
<input type="checkbox"/> Visual disturbances/blurry vision/double
<input type="checkbox"/> Ear noises/hearing loss
<input type="checkbox"/> Nausea/vomiting/vertigo
<input type="checkbox"/> Restricted movement-neck
<input type="checkbox"/> Pain around collar bone/front of neck
<input type="checkbox"/> Problems sitting/lying/bending/standing
<input type="checkbox"/> Pain/numbness/tingling into arms/hands
<input type="checkbox"/> Pain/numbness/tingling into legs/feet
<input type="checkbox"/> Problem rolling over/getting up and down
<input type="checkbox"/> Bowel problems: constipation/diarrhea
<input type="checkbox"/> Chest/ribcage pain/tightness/pressure
<input type="checkbox"/> Shoulder pain/dysfunction | <input type="checkbox"/> Difficulty breathing/painful breathing
<input type="checkbox"/> Problems sleeping due to pain
<input type="checkbox"/> Unexplained fatigue/loss of focus
<input type="checkbox"/> Low back pain/soreness/stiffness
<input type="checkbox"/> Hurts to cough/sneeze/move bowels
<input type="checkbox"/> Buttock/hip/tailbone pain
<input type="checkbox"/> Other pain/numbness/tingling
<input type="checkbox"/> Loss of muscle strength
<input type="checkbox"/> Swollen feet, ankles, or legs
<input type="checkbox"/> Pain between/under shoulder blades
<input type="checkbox"/> Problems walking: limp, drag foot
<input type="checkbox"/> Arthritis/stiff joints
<input type="checkbox"/> Knee, feet, or ankle pain
<input type="checkbox"/> Changes – Urinary habits: more/less
<input type="checkbox"/> Frequent/painful/burning urine
<input type="checkbox"/> Drug Reactions
<input type="checkbox"/> Other "New" Pain _____ |
|---|--|

Significant Illness: (Check any which apply)

- | | |
|---|--|
| <input type="checkbox"/> Heart trouble
<input type="checkbox"/> Cancer
<input type="checkbox"/> Mental/Depression
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Seizures/Stroke/TIA
<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Drugs/Alcohol
<input type="checkbox"/> Liver/Kidney/Spleen | <input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Colon/Stomach Problems
<input type="checkbox"/> Blood Clots/Embolism
<input type="checkbox"/> Asthma/Lung Disease
<input type="checkbox"/> HIV positive
<input type="checkbox"/> Other _____ |
|---|--|

Surgical Procedures: (Check any which apply, and write the year next to it.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendectomy
<input type="checkbox"/> Breast/implants
<input type="checkbox"/> Eye/Ear/Nose
<input type="checkbox"/> Heart/Lung
<input type="checkbox"/> Neck/Back
<input type="checkbox"/> Carpal Tunnel
<input type="checkbox"/> Bone Fusions | <input type="checkbox"/> Prostate
<input type="checkbox"/> Stomach/Pancreas
<input type="checkbox"/> Brain
<input type="checkbox"/> Hysterectomy/D&C/Tubal
<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Hernia
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Hip/Knee/Ankle/Foot
<input type="checkbox"/> Nerve
<input type="checkbox"/> Kidney
<input type="checkbox"/> Vasectomy/Artery/Vein
<input type="checkbox"/> Vascular
<input type="checkbox"/> Shoulder/Elbow |
|--|--|---|

Have you ever been given a permanent impairment rating? No__ Yes__

Patient Name: _____

Date: _____

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Accident/Injuries:

	<u>Describe Injury</u>	<u>Age</u>
Falls/Injuries?	_____	_____
Sports Injuries?	_____	_____
Auto Accidents?	_____	_____
Other?	_____	_____

Medications: (Circle for current conditions)

1. Over the counter: Advil Afrin Aleve Aspirin Benadryl Coldese Excedrin Goody's Midol Tylenol Others _____

2. Prescriptions – List all prescription drugs, antibiotics used and why you are taking them – who prescribed:

Nutritional Profile:

1. Amounts of vitamins A__iu B__mg C__mg D__mg E__iu K__ Multi_____

2. Circle all minerals taken daily: Calcium Chromium Copper Iodine Iron Magnesium Manganese MSM Phosphorous Potassium Selenium Sodium Sulfur Zinc

3. List all herbs/amino acids/others: _____

4. Did you ever smoke? N__ Y__ Do you smoke now? N__ Y__ (___# packs/day ___#yrs)
 Previous Smoker but quit in _____ (year) (___# packs/day for ___#yrs.)

5. Do you drink? N__ Y__ Type: Social or Daily (circle use below)
 Beer Coolers Wine Gin Rum Vodka Whiskey
 Previous but quit ___# drinks per ___day/ per week

6. Do you drink caffeine, coffee, tea, or sodas? N__ Y__ ___# day ___# week

7. How many glasses of water do you drink daily? _____

8. Number of times daily to empty bladder: ____ Bowels: ____

9. Times a day you eat veggies___ fruit___ meat___ bread___ fish___ nuts___

10. Describe your typical breakfast:

Patient Name: _____ **Date:** _____

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11. Describe your typical lunch:

12. Describe your typical dinner:

13. Describe any snacks you have on a regular basis:

After dinner?:

14. What kind of sweets do you eat? _____

15. How much salt do you use? _____

16. How often do you eat beef? _____ Pork? _____

17. How much raw food do you eat on a daily basis? _____

Symptoms Chart	Rate scale of 1-5 1 = least pain 5: = most pain	Comments Section
Indigestion ___Yes ___No	1 2 3 4 5	
Stomach Acidity ___Yes ___No	1 2 3 4 5	
Hiatal Hernia ___Yes ___No	1 2 3 4 5	
Heartburn ___Yes ___No	1 2 3 4 5	
Digestive Weakness ___Yes ___No	1 2 3 4 5	
Gas ___Yes ___No	1 2 3 4 5	
Bloating ___Yes ___No	1 2 3 4 5	
Ulcers ___Yes ___No	1 2 3 4 5	

18. Has your weight changed more than 10 lbs. In the past year? N__ Y__ _____# lbs.

Patient Name: _____ **Date:** _____

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19. Number of times you exercise each week: _____ for _____# minutes average

20. # of hours you sleep: _____ How many wakeups?_____ Dream? Y__ N__
What time do you go to bed?_____ How long until asleep?____ What time wake up?_____

Stress-Relaxation Profile:

Circle all stresses: Co-worker Boss Financial Home
Friend Child Parent Spouse
Ex-spouse Pain Emotional Mental-Health Issues
Personal-Health Issues Work too many hours

Circle all relaxation methods: Sleep TV Read Music Alcohol Smoking
Drugs Eating Walking Jog Run Swim Prayer
Meditate Centering Solitude Deep Breathing Quietness

Family History: review the disease categories and use the appropriate letter(s)

GP(grandparent) F(father) M(mother) B(brother) S(sister) C(child)

Aneurysms_____	Stroke/TIA_____
Arthritis _____	Kidney/Liver_____
Asthma_____	Low back pain_____
Alzheimer's_____	Mental illness/Depression_____
Cancer_____	Migraines_____
Diabetes_____	Multiple Sclerosis_____
Polio_____	Disc Degeneration_____
Blood Clots_____	Emphysema/Lung_____
Stomach/Pancreas_____	Epilepsy/Parkinson's_____
Headaches_____	Sinus Infections_____
Heart Attack_____	High Blood Pressure_____
Thyroid_____	Tuberculosis_____

For Women Only: Are you Pregnant? N__ Y__ Any chance? N__ Y__

Use birth control? N__ Y__ Pills Condoms Shots Diaphragm Herbs
Endometriosis Tubal Hysterectomy Vasectomy

Date last menstrual period began: _____

Do you have painful periods? N__ Y__

I affirm that the above pages and my color pain diagram are true and complete.

Patient Signature:_____ **Date:** _____



Notice of Privacy Practices Acknowledgment Form

I acknowledge that Dunn Chiropractic Wellness Center (otherwise known as “the Center” has provided me with a copy of its Notice of Privacy Practices. I understand this acknowledgment means only that I have received the notice, and in no way affects the care I receive.

I understand that the Center will contact me at home either via phone or postcard and that it is my responsibility to notify the office should I choose not to be contacted for appointment reminders.

I understand that the Center may contact me for purposes of providing information regarding treatment alternatives, services or goods and that it is my responsibility to notify the office should I choose not to be contacted regarding treatment alternatives, services or goods.

I understand that the Center utilizes a color pain diagram as my treatment sign-in. I understand that should I choose for other patients not to see my patient information that it is my responsibility to hold onto the sign-in page until it is requested.

I understand that the initial examinations are completed in total privacy, but that routine chiropractic treatment is rendered in a semi-privately designed room.

Print Name

Date

Patient’s Signature

Relationship to patient (if not patient)

This form will be placed in your chart and maintained for 6 years.

Records Release Authorization

To _____

Date _____ Phone _____ Fax _____

I, _____, do hereby declare that this request is made for the Continuation of Care with this Health Care Facility, staff and physicians. I request that you release any and all of the following medical records from my Confidential Health files:

ER notes; History & Physical Exam notes; Treatment notes; Admission documentation/diagnosis; Plain film/CT/MR reports; Surgical notes; Lab reports; Path reports; Discharge Summary; Electrodiagnostic studies; Physical therapy assessment, daily notes, discharge summary; or _____; to:

Dunn Wellness Center
Linda Banister, DC
H. Joseph Dunn, Jr., DC,
Marcus Kampfe, DC
390 Ninth Avenue North, Jacksonville Beach, FL 32250
Phone: (904) 249-1551, Fax: (904) 249-1530

This authorization will expire in six months from above date unless otherwise specified here _____ / _____ (initials) and I may revoke this authorization at any time in writing.

Signature (Patient or Guardian)

Date of Birth

Address

Social Security Number

City State Zip

Witness

Financial Policy Statement

Dear Patient:

We appreciate your decision to select our office for your healthcare needs. Our main concern is you and that you understand your condition and receive the proper care needed to restore your health. We hope that you understand that our financial policy is a necessary part of assuring the financial resources required in operating a professional healthcare facility for our community. Therefore we have implemented the following financial policy. We ask that you read, agree, and sign the financial policy prior to seeing a provider.

Payments for services are due at the time of service, unless prior arrangements have been made. We accept cash, check, and for your convenience, credit and debit cards. We will be happy to send your insurance claim to your carrier as long as you provide us with your current and accurate insurance information. Currently we participate with Aetna, Blue Cross Blue Shield, Humana, and a number of other plans. Some plans require a referral from your primary care physician and/or an authorization number from your insurance company before we can render professional services under your policy. Correct identification of your policy will allow us to submit an accurate claim on your behalf. Maintenance care can not be billed to a third party insurance carrier. We must emphasize the following:

- Co-payments and deductibles are due at the time of service.
- If your plan requires a referral, you are required to obtain that referral prior to your appointment. If you do not obtain the referral, you (the patient) are responsible for payment in full at the time of service.
- Not all services are covered under the benefits of certain plans. Any charges not paid by the insurance companies are the responsibilities of the patient. Including Health Savings Accounts (HSAs).
- If your insurance does not pay in full within 45 days, we ask that you contact the customer service department of you insurance company to expedite payment to the center.
- If your insurance does not pay in full within 60 days, we require you to pay the balance due within 10 days of notice.
- We do not accept assignment on out of state policies that are not governed by the Florida Department of Insurance.
- We do not do secondary billing if you have a multiple policy benefits without an additional fee of \$35 for filing.
- Returned checks are subject to a \$50 return check fee to cover bookkeeping and bank expenses.
- All balances older than 90 days will be reviewed and turned over to an outside collection agency if payment arrangements have not been resolved.
- **If you miss a scheduled appointment without the proper 24 hour notice, we reserve the right to charge a fee of \$20.**

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that we can assist you in the management of your account. Again, thank you for choosing us for you health care needs, and we appreciate the opportunity to serve you.

Patient's

Signature _____ **Date** _____

By my signature above, I indicate that I have read this policy, and agree to its provisions.