

NEW PATIENT FORM:

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

E-Mail Address: _____

Social Security #: _____ Birthday: _____ Age: _____ Sex: M F Marital Status: S M W D

Employer: _____ Occupation: _____

Spouse's Name: _____ Employer: _____ Occupation: _____

Referred by: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Name of person responsible for paying this bill: _____ Relationship _____

Address: _____ Phone: _____

SS# _____ Employer: _____

INSURANCE INFORMATION:

Name of insurance company: _____

Name of policy holder : _____ Policy holders SS# _____ DOB _____

Name of secondary insurance: _____

Do you have public aid? Y N Medicare? Y N

Is this a work related injury? Y N Motor vehicle accident? Y N

When did your symptoms begin? _____

I will be paying **today** by: _____ cash _____ check _____ charge/debit card

Why did you choose Chiropractic? _____

Have you ever seen a Chiropractor before? Y N When? _____

Where? _____

AUTHORIZATION AND ASSIGNMENT

In consideration of you taking care of me, I agree to the following:

1.) You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2.) I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

Date _____ Signature _____

I authorize Dr. Frank C. Bemis & associates to examine and treat my minor child

Child's Name _____ Signature _____

Date _____ Witness _____

Patient Name _____ Age _____ Birthday _____

Date of last physical examination _____ M.D. _____

What is your reason for this visit? _____

Symptoms

Check symptoms you currently have or have had in the past year.

GENERAL

- CHILLS
- DEPRESSION
- DIZZINESS
- FAINTING
- FEVER
- FORGETFULNESS
- HEADACHES
- LOSS OF SLEEP
- LOSS OF WEIGHT
- NERVOUSNESS
- NUMBNESS
- SWEATS

MUSCLE/JOINT/BONE

PAIN ,WEAKNESS, NUMBNESS IN,

- ARMS
- BACK
- FEET
- HANDS
- HIPS
- LEGS
- NECK
- SHOULDERS

WOMEN ONLY

- ABNORMAL PAP SMEAR
- BLEEDING BETWEEN PERIODS
- BREAST LUMP
- EXTREME MENSTRUAL PAIN
- HOT FLASHES
- OTHER

GASTROINTESTINAL

- APPETITE POOR
- BLOATING
- BOWEL CHANGES
- CONSTIPATION
- DIARRHEA
- EXCESSIVE THIRST
- EXCESSIVE HUNGER
- GAS
- HEMORRHOIDS
- INDIGESTION
- NAUSEA
- RECTAL BLEEDING
- STOMACH PAIN
- VOMITING
- VOMITING BLOOD

EYES, EARS, AND THROAT

- BLURRED VISION
- DIFFICULTY SWALLOWING
- DOUBLE VISION
- EARACHE
- EAR DISCHARGE
- HAY FEVER
- VISION-FLASHES

GENITO-URINARY

- BLOOD IN URINE
- FREQUENT URINATION
- LACK OF BLADDER CONTROL
- PAINFUL URINATION

CARDIOVASCULAR

- CHEST PAIN
- HIGH BLOOD PRESSURE
- IRREGULAR HEART BEAT
- LOW BLOOD PRESSURE
- POOR CIRCULATION
- RAPID HEART BEAT
- SWELLING OF ANKLES
- VARICOSE VEINS

- HOARSENESS
- LOSS OF HEARING
- NOSEBLEEDS
- PERSISTENT COUGH
- RINGING IN EARS
- SINUS PROBLEMS
- VISION-HALOS

Date of last menstrual period _____

Are you pregnant? _____

Number of children _____

Date of bone density testing (if applicable) _____

Medications:

Please **PRINT** medications you are currently taking

Allergies:

Supplements:

Conditions:

Check symptoms you currently have or have had in the past year.

- | | | | |
|----------------------|--------------------|----------------------|---------------------|
| 0 AIDS | 0 CHEM. DEPENDENCY | 0 HIGH CHOLESTEROL | 0 PROSTATE PROBLEMS |
| 0 ALCOHOLISM | 0 CHICKEN POX | 0 HIV POSITIVE | 0 PSYCHIATRIC CARE |
| 0 ANEMIA | 0 DIABETES | 0 KIDNEY DISEASE | 0 RHEUMATIC FEVER |
| 0 ANOREXIA | 0 EMPHYSEMA | 0 LIVER DISEASE | 0 SCARLET FEVER |
| 0 APPENDICITIS | 0 EPILEPSY | 0 MEASLES | 0 STROKE |
| 0 ARTHRITIS | 0 GLAUCOMA | 0 MIGRAINE HEADACHES | 0 SUICIDE ATTEMPT |
| 0 ASTHMA | 0 GOITER | 0 MISCARRIAGE | 0 THYROID PROBLEMS |
| 0 BLEEDING DISORDERS | 0 GONORRHEA | 0 MONONUCLEOSIS | 0 TONSILITIS |
| 0 BREAST LUMP | 0 GOUT | 0 MULTIPLE SCLEROSIS | 0 TUBERCULOSIS |
| 0 BRONCHITIS | 0 HEART DISEASE | 0 MUMPS | 0 THYROID FEVER |
| 0 BULIMIA | 0 HEPATITIS | 0 PACEMAKER | 0 ULCERS |
| 0 CANCER | 0 HERNIA | 0 PNEUMONIA | 0 VENEREAL DISEASE |
| 0 CATARACTS | 0 HERPES | 0 POLIO | |

Family History:

	AGE	HEALTH STATUS	AGE AT DEATH	CAUSE OF DEATH
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
SISTER	_____	_____	_____	_____
SISTER	_____	_____	_____	_____
SISTER	_____	_____	_____	_____

CHECK IF YOUR BLOOD RELATIVES HAVE/HAD THE FOLLOWING:

- | | | |
|--------------------------|-----------------------|------------|
| <input type="checkbox"/> | ARTHRITIS, GOUT | WHOM _____ |
| <input type="checkbox"/> | ASTHMA, HAY FEVER | WHOM _____ |
| <input type="checkbox"/> | CANCER | WHOM _____ |
| <input type="checkbox"/> | DIABETES | WHOM _____ |
| <input type="checkbox"/> | HEART DISEASE, STROKE | WHOM _____ |
| <input type="checkbox"/> | HIGH BLOOD PRESSURE | WHOM _____ |
| <input type="checkbox"/> | KIDNEY DISEASE | WHOM _____ |
| <input type="checkbox"/> | TUBERCULOSIS | WHOM _____ |

Hospitalizations/Surgeries

YEAR	HOSPITAL	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pregnancies

BIRTH YEAR	COMPLICATION (IF ANY)
_____	_____
_____	_____
_____	_____
_____	_____

Occupational:

Check, IF your work exposes you to the following:

STRESS HEAVY LIFTING REPETITIVE MOVEMENTS HAZARDOUS SUBSTANCES

OTHER _____ OCCUPATION _____

Accidents/Illnesses/Injuries:

DATE _____ OUTCOME _____

DATE _____ OUTCOME _____

DATE _____ OUTCOME _____

Health Habits: Check which substances you use and describe how much you use:

___ CAFFEINE _____ ___ TOBACCO _____

___ DRUGS _____ ___ OTHER _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by: _____ Date _____

Dr. Frank C. Bemis & Associates
4105 Humbert Road
Alton, IL 62002
618-463-1600 or
800-FC BEMIS

OFFICE POLICY / FINANCIAL POLICY

We believe that a clear definition of our office policies will allow you, the patient, and our office to concentrate on the big issue

REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY: Multiple appointments may be scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of the visits that count, and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within 7 days of any cancellation. When entering our office on any given visit, please go directly to the front desk and "sign in". We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments please do not hesitate to speak to Debbie.

FINANCIAL POLICY:

CHILDREN: Children as well as adults benefit from chiropractic care. In an effort to make this affordable for the parents, we have a special policy for children. All children will be charged \$15.00 per adjustment. This fee structure will apply to children 12 years of age and younger. Once a child reaches the age of 13 years, they will be converted to adult prices. This special price is for chiropractic adjustments only. It does not affect any ancillary services such as x-rays, examination, or therapy.

CASH PATIENTS: Patients without the benefit of chiropractic coverage on their insurance are responsible to pay 100% of their charges as services are rendered. If care becomes extensive, a payment agreement can be provided which will spell out a monthly amount. Your balance may never exceed \$250.00 at any time, unless you have been set UP on a payment plan.

GENERAL INSURANCE: Patients who have chiropractic benefits on their insurance policies are required to provide this office with all necessary billing information, including but not limited to, addresses, phone numbers, and policy numbers within five working days of their initial date of service. Patients who fail to do so will become a cash patient on day 5 and any balance must be paid in full at that time. As a courtesy to you we will bill your insurance company and wait for payment. Your obligation is to pay any and all deductibles and co-payments as you go. You are also responsible for any "non-covered" services. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember, the care and services were provided to you and not your insurance company. You are responsible for all cost incurred in this office.

MEDICARE: As a participating provider with Medicare, we will accept what Medicare approves for your adjustments. Please be aware that Medicare covers only chiropractic adjustments. Medicare does not pay for any other services performed at our office.

PUBLIC AID: If you are on public assistance, we will bill the state agency for your chiropractic adjustments. Public aid covers your chiropractic adjustments only. Public aid does not cover any ancillary services, such as exams, x-rays, therapy, and supports. You will be 100% responsible for these services at the time they are performed.

MEDICARE COMPLETE: See Debbie for special requirements.

PPO/HMO: Each PPO coverage is different; our office will make every attempt to verify your coverage for you. If your policy requires a referral, it is your responsibility to get the necessary referrals from your primary care physician (PCP).

WORKERS COMPENSATION: All patients covered by Illinois Workers Compensation are required to file an accident report with their employer. It is your responsibility to provide all necessary billing information to this office within five working days of your initial visit. Failure to do so will make you a cash patient and payment in full will be required on day five. If you have retained an attorney, you are also further required to provide this office with all attorney information. If you are a Missouri Workers Compensation patient, the laws require you, in your state, to get your employer's approval to come to this office. Without this approval, Missouri Workers Compensation will not pay for your care.

PERSONAL INJURY: All patients involved in a personal injury, such as a motor vehicle accident, are required to provide all necessary billing information and attorney information to this office within 5 working days of your initial visit. Failure to do so will make you a cash patient and payment in full of any outstanding balance will be required on day five. If you have retained an attorney you will be asked to sign a lien to protect any outstanding balance in this office at the time of settlement. Please be advised that we have contacted all local attorneys, in writing, and notified them that this office will not cut our bill or make deals. Any outstanding balance not paid at the time of settlement is YOUR responsibility. This office will bill ALL liability parties including the medical pay portion of your own car insurance, regardless of who was at fault.

Unlimited Chiropractic Care at A Fixed Fee: (UCCAFF) Our office has a policy available for a patient to receive unlimited chiropractic treatments with a financial discount. This has been proven to be cost-effective and more affordable with the rising cost of health care. Please inquire at the time of consultation with the doctor to discuss the different options.

I fully understand that I am directly and fully responsible to DR. FRANK C. BEMIS & ASSOCIATES for all chiropractic services provided to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment by me is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fees.

I, the undersigned, expressly state that in the event that I fail to make payment to this office for any and all cost incurred as a result of the chiropractic services rendered within a reasonable period of time, that I agree to pay the cost of collection, including reasonable attorney's fees as provided by law.

I further understand that the care was provided to ME, not my insurance company, employer, and or attorney. Therefore, I am solely responsible for my account.

Signature: _____ Date: _____

Signature: _____ Date: _____