Chiro+Plus

5205 E. Kellogg Drive | Wichita KS 67206
TF: 800.776.3847 | PH: 316.684.0550 | www.ChiroPlus.com

PATIENT DATA SHEET

NAME _____

SPOUSE NAME _____

MARITAL STATUS ○ Married ○ Single ○ Divorced ○ Widowed

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

PHONE (HOME) _____

PHONE (WORK) _____

PHONE (CELL) _____

_____

BIRTHDATE _____ AGE _____

SS# (FOR INSURANCE) _____

EMPLOYMENT _____

TITLE _____

DUTIES _____

_____

REFERRED BY: _____

RECREATION ACTIVITIES

TYPE	FREQ/WK	INTENSITY
_____	_____	_____
_____	_____	_____
_____	_____	_____

REHAB/DIET PROGRAMS

TYPE	FREQ/WK	INTENSITY
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURED OR RESPONSIBLE PARTY ○ SELF ○ SPOUSE ○ PARENTS

○ WORK COMP ○ HOME INSURANCE ○ AUTO INSURANCE

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____

PHONE (WORK) _____

PHONE (CELL) _____

EMAIL _____

BIRTHDATE _____ AGE _____

SS# (FOR INSURANCE) _____

CLAIMS NUMBER _____

INSURANCE COMPANY _____

CONTACT PERSON _____

EMPLOYMENT _____

EMERGENCY CONTACT

NAME _____

PHONE (HOME) _____

PHONE (CELL) _____

PURPOSE OF THIS APPOINTMENT _____

_____

_____

_____

_____

MEDICAL HISTORY

PATIENT'S NAME _____ **DATE** _____ **DOB** _____ **FILE #** _____

List any accidents and falls you have ever had, including work and auto:

1. _____ **Year** _____

2. _____ **Year** _____

3. _____ **Year** _____

4. _____ **Year** _____

List any major surgeries you have ever had:

1. _____ **Year** _____

2. _____ **Year** _____

3. _____ **Year** _____

4. _____ **Year** _____

List any fractures you have ever had:

1. _____ **Year** _____

2. _____ **Year** _____

3. _____ **Year** _____

4. _____ **Year** _____

List major illnesses you have ever had:

1. _____ **Year** _____

2. _____ **Year** _____

3. _____ **Year** _____

4. _____ **Year** _____

MEDICAL PHYSICIAN _____

TOWN/LOCATION _____

PHONE _____

MEDICAL PHYSICIAN _____

TOWN/LOCATION _____

PHONE _____

What is your general state of health? ○ Excellent ○ Good ○ Fair ○ Poor

When was the last time you really felt good? _____Weeks _____Months _____Years

DIAGNOSIS _____

DIAGNOSIS _____

DIAGNOSIS _____

DATE OF LAST MEDICAL EXAM _____

WHAT PROMPTED EXAM _____

DATE OF LAST LAB WORK _____

DATE OF MOST RECENT X-RAYS _____

BODY PARTS X-RAYED _____

_____

TREATMENT _____

TREATMENT _____

TREATMENT _____

LAST CHIROPRACTIC TREATMENT _____

TYPE OF TREATMENT _____

NAME OF DOCTOR _____

LOCATION _____

NUMBER OF TREATMENTS _____

END RESULTS ○ **Good** ○ **Fair** ○ **Poor**

Medical History

Patient's Name_____ **DOB**_____ **Date**_____ **File#**_____

Four factors contribute to your state of health:

1. Neurological integrity of Mind I Body connection
2. Hormonal balance & Metabolic processing
3. Lifestyle activities & Nutrition
4. Genetic & Familial history

Please provide the following Information ofyour grandparents. parents, or siblings.

Have any of them had the following? G P S

_____ Allergies I Asthma I Crohns

_____ Arthritis I Scoliosis I Spina Bifida

_____ Mental Illness I Social Dysfunctions

_____ Liver I Gall Bladder Disease

_____ Cerebral Vascular Stroke

_____ Diabetes

_____ Thyroid Disease

_____ Kidney I Urinary Tract Dysfunctions

_____ Respiratory Disease I Emphysema

_____ High Blood Pressure

_____ Heart Disease I Murmurs

_____ Cancer I AIDS I HIV

_____ Digestive Diseases I Ulcers I IBS

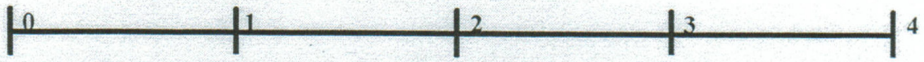
_____ Multiple Sclerosis I ALS

Do you take any ofthe following?	NO	YES	More Details ofType	How Long?
Vitamin / Mineral Supplements				
Herbs / Laxatives				
Pain Meds / Muscle Relaxants				
Sedatives / Tranquilizers				
Birth Control Pills				
Hormone Replacement Therapy				
Blood Pressure Medicine				
Insulin				
Other Prescribed Medicine				
Over the Counter Products				
Recreational Drugs				
Tobacco				
Alcohol				
Coffee				
Diet soda / Artificial Sweeteners				
Electric Blanket / Magnets				
Cell Phone / Pager				

Kinesiology Functional Rating Index

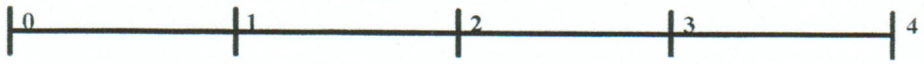
To properly assess your condition, we must know how much your health problems have affected your everyday activities. For each item below, please circle the number which most closely represents your condition today.

Pain Intensity



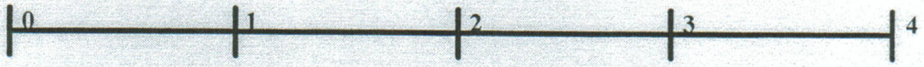
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst pain possible

Sleeping



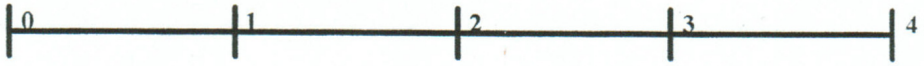
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

Personal Care
Washing, dressing...



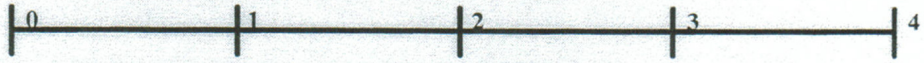
0	1	2	3	4
No pain No restrictions	Mild pain No restrictions	Moderate pain Dress slowly	Moderate pain Dress with assistance	Severe pain 100% assistance

Travel
Driving / Riding



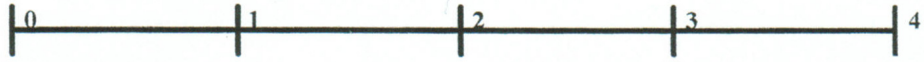
0	1	2	3	4
No pain on 3 hour trip	Mild pain on 3 hour trip	Moderate pain on 3 hour trip	Moderate pain on 1/2 hour trip	Sever pain on 1/2 hour trip

Work



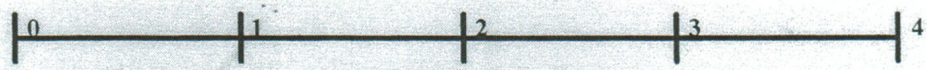
0	1	2	3	4
Do usual work plus Extra work	Do usual work No Extra work	Do 50% of my usual work	Do 25% of my usual work	Cannot work

Recreation



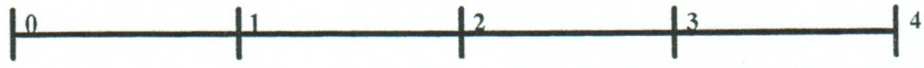
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

Frequency of pain



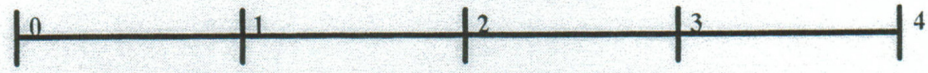
0	1	2	3	4
No pain	Occasional pain 25% of a day	Intermittent pain 50% of a day	Frequent pain 75% of a day	Constant pain 100% of a day

Lifting



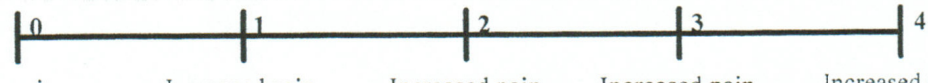
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light-weight	Increased pain with any weight

Walking



0	1	2	3	4
No pain Any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with any walking

Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain After 1/2 hour	Increased pain with any standing

Signature _____ Date _____

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Financial Policy

Office Fees

- New Patient Evaluation PLUS doctor's report & initial procedures **$190**
- New Patient Child Evaluation PLUS doctor's report & initial procedures **$160**
- 12 Month Reactivation Exam PLUS doctor's report & initial procedures **$140**
- 6 Month Reactivation Exam PLUS doctor's report & initial procedures **$120**
- 3 Month Reactivation Exam PLUS doctor's report & initial procedures **$100**
- Progress Evaluation Exam PLUS progress report & continued procedures .....**$ 90**

The policies for billing and filing of insurance are designed and regulated by the insurance commissioner of Kansas. Each insurance company has different standards and each policy has its unique coverage so please note the following...

· We do not have a contract with any insurance company... you do! To acquire your benefits you may need to consult your insurance carrier about your coverage. We will no longer contact your insurance company to file for your reimbursements.

· We will provide you with information and records so you can mail your own claim to your insurance carrier. Your reimbursement will be sent to your home. Your policy deductible will require a certain amount of cash payment by you at the beginning of each fiscal year of your policy before any reimbursements are received.

Signature _____ **Date**_____

Medicare Waiver of Liability
Advanced Beneficiary Notice

This includes all services in our office throughout your treatment plan.

Chiro+Plus Kinesiology Clinic

5205 E. Kellogg Drive
Wichita, KS 67218

PROVIDER NOTICE

"Medicare will only pay for services that they determine to be 'reasonable and necessary' under section 1862(a) (1) of the Medicare law. If Medicare determines that a particular service is not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment."

BENEFICIARY AGREEMENT

"I have been notified by my provider that he/she believes that in my case Medicare is likely to deny payment for services. If Medicare denies payment, I agree to be personally and fully responsible for payment."

_____ DATE _____

(SIGNATURE OF PATIENT)