

Patient Name: _____ Birthdate: ____/____/____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

CIRCLE which telephone # to leave appointment reminders or health related messages:

Home: _____ Work: _____ Cell: _____

Do you give permission to: _____ Leave Health Related Messages? _____ Send Text Messages?

___ Married ___ Single ___ Partner ___ Widow/Widower Number of kids _____

Email Address: _____

Parent/Guardian/Caregiver Name (for minor patient): _____ Phone: _____

Insurance Carrier(s): _____ Policyholder's Employer: _____

Policyholder's Name: _____ Policyholder's Birthdate: _____

Emergency Contact Name: _____ Phone Number: _____

Primary Care Physician: _____ PCP Phone: _____

Have you had chiropractic care before? Yes ___ No ___ If yes, for what issue? _____

Whom can we thank for referring you to this office? _____

Date Symptoms Began: _____ Describe your current problem and how it began: _____

Do you perform any repetitive movement in your work, sports, or hobby? ___ Yes ___ No
If yes, please describe _____

Is Your Current Problem? : ___ Work Related ___ Auto Accident Related ___ Personal Injury ___ None

Current Pain Level TODAY (0 = No Pain and 10 = Unbearable Pain): _____

In the past week, how much has your pain interfered with your daily activities (work, social activities, household chores)? (0= No interference to 10 = unable to carry on any activities): _____

Do you exercise? ___ Yes ___ No What & How Much? _____

Do you drink Alcohol? ___ Yes ___ No How many per day? _____ How many ounces of water do you drink per day? _____
Do you drink Caffeinated Beverages? ___ Yes ___ No How many per day? _____

Family History: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart/Stroke ___ Rheumatoid Arthritis
Other: _____

Signature: _____ Date: ____/____/____

STELMACK PINPOINT HEALTH CARE

Please list ALL MAJOR past illness/injuries (concussions, head injuries, cancer, broken bones, high blood pressure, car accidents, work related, etc.) you have had which did or did not require hospitalization, please include dates:

Please list ALL major surgeries/operations. List when and where done and the name of the surgeon and if you have any remaining problems associated with these procedures.

Please list ALL medications & nutritional supplements (including birth control pills, aspirin, vitamins, minerals) even if only occasionally. Include how often, dosage and how long you have been taking it.

Please check any condition listed that applies to you: Contagious Skin Condition Open Sores/Wounds
 Easy Bruising Decreased Sensation Phlebitis Blood Clots Headaches/Migraines
 Sprains/Strains Swollen Glands Osteoarthritis Tendonitis Varicose Veins Fibromyalgia
 Fever Atherosclerosis

Are you allergic to anything (medications, food, oil, lotion, etc.)? Yes No If yes, what?

Do you smoke? Yes _____ How much? _____ How Long? _____ No _____

Women only:

Are you pregnant or think you might be pregnant? _____

Date of last menstrual period: _____

Do you or have you suffered from any menstrual disorders? Yes No

If yes, please describe:

Signature: _____ Date: ____/____/____

Use the appropriate symbol(s) listed below.

ACHING XXXX
XXXX

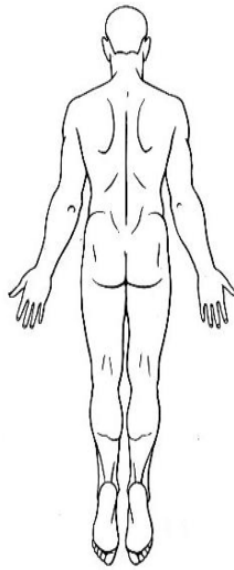
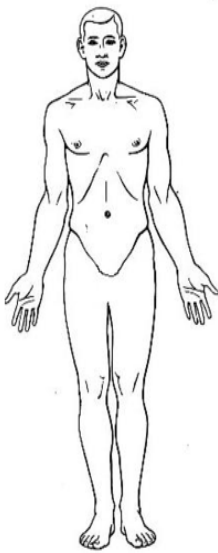
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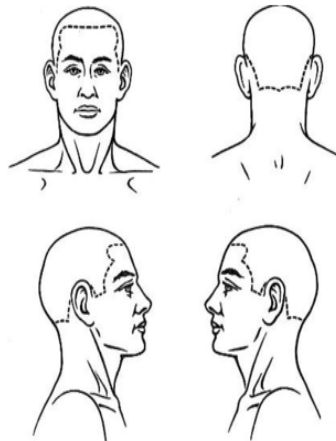
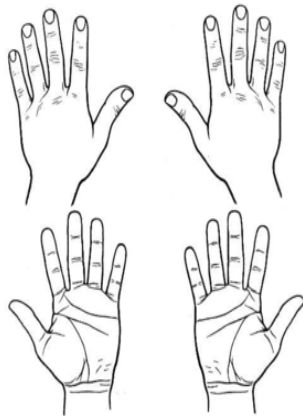
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THROBBING ++++
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HEADACHES ↓



Signature: _____

Date: ___/___/___

FINANCIAL POLICY

Thank you for choosing Stelmack Pinpoint Health Care as your chiropractic physician office. We are committed to providing you and your family with the best chiropractic care. In our ongoing process to make sure that all your needs are met, our billing department will be available to discuss fees and this policy with you.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard and Discover. As a courtesy to you, it is our policy to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

(Please initial the following)

___ 1. Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges. As your medical provider, we will only supply factual information to facilitate claim processing.

___ 2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time service. Returned checks and unpaid balances may be subject to collection placement and collections fees.

___ 3. All charges are your responsibility whether your insurance carrier pays or does not pay. If your insurance does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Stelmack Pinpoint Health Care, you recognize the obligation to promptly remit payment to this office.

___ 4. You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney, you will be responsible for all the costs of collecting monies owed, including court costs, collection fees and attorney fees.

___ 5. The above does not apply for those patients that are considered Workers' Compensation or Auto Accident claims. However, be advised that as a compensation or MVA patient, you may be held responsible for charges in the event that your claim is controverted.

___ 6. We ask that you provide us with 24 hour notice of cancelled appointments, failure to do so will result in a \$25 fee. **You acknowledge this \$25 fee will be incurred if you miss an appointment and do not provide 24 hour notice.**

We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing.

I have read and understand the above information and will be responsible for the patient listed below.

Print Name of Patient: _____ Date of Birth: ____/____/____

_____/_____/_____
Signature of Patient or Responsible Party Date