Belnap Chiropractic
REGISTRATION

Date_____

Patient_____ Home Phone_____
Last Name First Name Middle Initial

Street Address_____ City_____ State_____ Zip_____

Birth Date_____ Age_____ ❒Single ❒Married ❒Widowed ❒Separated ❒Divorced # of children____

Social Security #_____ Email Address_____

Condition Related to: ❒Auto Accident ❒Work-related Injury ❒Other Injury ❒Illness ❒Unknown

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ City_____ State_____ Zip_____
SPOUSE	Name_____ Last Name First Name Middle Initial Birthdate_____ Social Security #_____ Employer Name_____ Occupation_____ Address_____ Phone_____
INSURANCE INFORMATION	**Health Insurance (if you have card, please give it to receptionist to make copy)** Insurance_____ Insured's Name_____ Group #_____ ID#_____
MEDICAL AND LEGAL INFORMATION	Family Physician_____ Phone_____ Attorney (if auto or work-related)_____ Phone_____ Known Medical Problems_____ _____ Person to contact in emergency (Name & Phone #)_____ _____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Belnap Chiropractic all medical benefits otherwise payable for services. I understand that I am financially responsible for all charges whether or not paid by insurance, and I have read and understand the financial policy of this office. I authorize the use of this signature on all my insurance submissions and to obtain records. _____ _____ Signature of Insured/Guardian Date

How did you learn of our practice? ❒Yellow Pages ❒Personal referral ❒Drive by/Sign ❒Other

If you were referred, whom may we thank?_____

BELNAP CHIROPRACTIC

Cameron J. Belnap, D.C.
723 16th Ave. So
Nampa, Id 83651

Financial Policy

Welcome to our office! The following information will answer most questions regarding finances. Please review the information that applies to you. We offer several methods of payment for your care at our clinic and you may choose the plan which best suit your needs. This information will enable us to better serve you and it will also help to avoid any misunderstandings. If special arrangements are necessary, please consult with Dr. Belnap. If any questions arise, our receptionist will be happy to assist you further.

PLAN #1: CASH: We request payment as services are rendered, unless special arrangements have been made in advance. You may use cash, visa, mastercard, discover or post-dated checks.

PLAN #2: PRIVATE INSURANCE: Most insurance companies provide chiropractic coverage. Nearly all insurances have a deductible or co-pay that is payable by you. We will bill your primary insurance company as a service for you. **You** are responsible to provide us with policy and group numbers, address, and phone number of your insurance. If your insurance denies coverage you are responsible for the charges.

PLAN #3: WORKMAN'S COMPENSATION: We treat many on-the-job injuries and handle the necessary reports and billings. **It is mandatory that you immediately fill out the accident report forms with your employer.** If the claim is accepted, workman's compensation insurance will pay for your care with exception of supplements. If the workman's compensation carrier or your employer deny responsibility for the injury the account will be payable by you.

PLAN #4: AUTO ACCIDENT: You must notify your insurance company of this accident, whether you are responsible or not. If your auto policy has medical coverage it will normally pay your chiropractic care. We will handle the necessary reports and billings for you. **Important:** If the auto insurance settles with you, it is **your responsibility** to immediately forward payment to us. Any amounts disputed or not paid by auto insurance are payable by you. **Subrogation:** If your accident is due to the fault of another, the other insurance will not pay until you reach a settlement. This could go on for several years. Your insurance will cover your bills and be paid by the responsible persons insurance at the time of settlement. If there is no medical coverage benefits under your insurance policy talk with our receptionist, she will be happy to assist you. If the accident is your fault, your insurance may cover your care up to your maximum medical coverage.

Outstanding accounts are subject to a 1.5% per month billing charge. Overdue accounts may be referred to collections or legal action.

I have read and understand the financial policies of the clinic for fee payment. I also understand that health and accident insurance policies are an arrangement between an insurance company and myself, not Belnap Chiropractic.

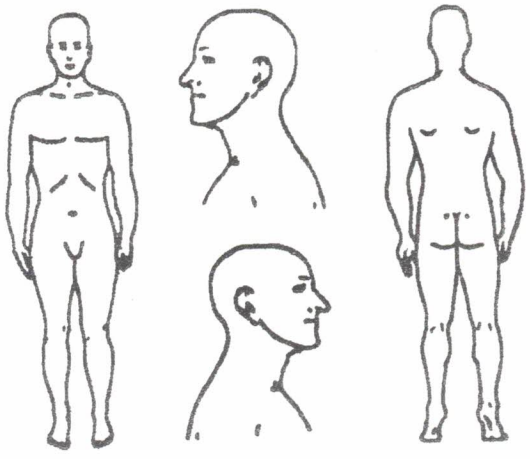
The plan that I have chosen for payment is : _____

Signature: _____ **Date:** _____

BELNAP CHIROPRACTIC CASE HISTORY

Name: _____ Date: _____

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE DIAGRAM BELOW



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

_____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Have you had Chiropractic care for other problems? YES - NO When and for what? _____

_____

What is your SECOND complaint? _____

Date problem began?_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

_____

List any **Allergies**:

Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen

Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

List any **Surgeries/Hospitalizations**:

Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

_____

_____

List **ALL Past Medical History** conditions:

Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain Depression

Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue Foot Pain

Genetic Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis High Blood Pressure

Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain Menstrual Problems Mid-Back Pain

Minor Heart Problem Multiple Sclerosis Neck Pain Neurological Problems Pacemaker Parkinson's

Polio Prostate Problems Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain

Stroke/Heart Attack Other: _____

List Type of **Medications** you are taking:

Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure

Other: _____

_____

List your **Family History**:

Arthritis Asthma Back Pain Cancer Depression Diabetes Epilepsy Genetic Spinal Condition

High Blood Pressure Heart Problems Multiple Sclerosis Neurological Problems Parkinson's Polio

Prostate Problems Stroke/Heart Attack Other: _____

Have you had any auto or other accidents? No Yes

Describe: _____

Date of last physical examination: _____ Spinal X-ray_____ Blood Test_____

Do you smoke? No Yes – how many per day? _____ For how long? _____

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____

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

Patient Signature:_____ Date:_____

Belnap Chiropractic

Cameron J. Belnap, D.C.

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature_____

Date_____

723- 16th Ave. South • Nampa, Id 83651 • 208-466-1600