

# Arbor Vitae Chiropractic Clinic

## NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions below.

Name: (Full) \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced  Legally Separated

e-mail Address: \_\_\_\_\_ Can we contact you by e-mail? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax/Work E-Mail \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Do you have health Insurance?  Yes  No Insurance Co: \_\_\_\_\_

Deductible \_\_\_\_\_ Copay? \_\_\_\_\_ Who is the guarantor? \_\_\_\_\_

Method of payment for first visit:  Cash  Check  Credit Card

Have you had previous Chiropractic Care?  Yes  No How long has it been since your last x-ray? \_\_\_\_\_

If yes, Doctor's Name: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

Is your pain the result of an: Auto Accident?  No  Yes Work Injury?  No  Yes \_\_\_\_\_

Are you currently involved in any legal action involving this injury?  No  Yes What? \_\_\_\_\_

Are you taking prescription medications now?  Yes  No Over the counter?  Yes  No

List: \_\_\_\_\_

Please list any Vitamins, Minerals, Herbs, or Nutritional Products that you are currently taking:

**For Women:** Last Menstrual Period: \_\_\_\_\_ Are you pregnant? \_\_\_\_\_ Due? \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize Dr. Lubkeman to provide treatment to the above named individual for conditions that fall under the scope of chiropractic care.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Arbor Vitae Chiropractic Clinic

## CURRENT HEALTH CONDITION

Main Complaint(s) \_\_\_\_\_

Rate Pain on a scale of: (circle, 1-mild to 10 severe)      1 2 3 4 5 6 7 8 9 10

How did the pain start? \_\_\_\_\_

How often do you have the pain?    0-25%   25-50%   50-75%   75-100%   of the (circle):   Day   Week   Month

How long have you had it? \_\_\_\_\_ Have you had it before?   No   Yes   When \_\_\_\_\_

Is the pain worse in the:            Morning    Afternoon    Night    No Difference

Does the Pain Radiate?            No            Yes    Where? \_\_\_\_\_

**Quality**

- |                                   |                                   |                                    |                                   |                                    |                                 |
|-----------------------------------|-----------------------------------|------------------------------------|-----------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Sharp    | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning  | <input type="checkbox"/> Deep      | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Cramping  | <input type="checkbox"/> Numbness | <input type="checkbox"/> Radiating |                                 |

**Aggravating Factors**

- |                                     |                                       |                                       |                                    |   |   |
|-------------------------------------|---------------------------------------|---------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Sitting    | <input type="checkbox"/> Standing     | <input type="checkbox"/> Walking      | <input type="checkbox"/> Bending   | <input type="checkbox"/> Stooping         | <input type="checkbox"/> Lifting        |
| <input type="checkbox"/> Sleeping   | <input type="checkbox"/> Sneezing     | <input type="checkbox"/> Coughing     | <input type="checkbox"/> Straining | <input type="checkbox"/> Reaching         | <input type="checkbox"/> Twisting       |
| <input type="checkbox"/> Looking up | <input type="checkbox"/> Looking Down | <input type="checkbox"/> Movement     | <input type="checkbox"/> Rest      | <input type="checkbox"/> Lying on back    | <input type="checkbox"/> Driving        |
| <input type="checkbox"/> Typing     | <input type="checkbox"/> Scooping     | <input type="checkbox"/> House Chores | <input type="checkbox"/> Exercise  | <input type="checkbox"/> Lying on stomach | <input type="checkbox"/> Stair Stepping |

**Relieving Factors**

- |                                      |                                     |                                |  |  |
|--------------------------------------|-------------------------------------|--------------------------------|--|--|
| <input type="checkbox"/> Sitting     | <input type="checkbox"/> Standing   | <input type="checkbox"/> Lying | <input type="checkbox"/> Knees Bent          | <input type="checkbox"/> Support           |
| <input type="checkbox"/> No Movement | <input type="checkbox"/> Movement   | <input type="checkbox"/> Heat  | <input type="checkbox"/> Ice                 | <input type="checkbox"/> Topical Analgesic |
| <input type="checkbox"/> Ibuprofen   | <input type="checkbox"/> Medication | <input type="checkbox"/> Rest  | <input type="checkbox"/> Stretching/Exercise | <input type="checkbox"/> Adjustments       |

Other Doctors Seen for this condition: \_\_\_\_\_ When: \_\_\_\_\_

Recommendations or Treatment: \_\_\_\_\_

Additional health concerns/complaints in order of seriousness. Rate pain on scale of 1-10

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Anyone in your family with similar problems? \_\_\_\_\_ If yes, who? \_\_\_\_\_

**Past Health History**

Major Surgery/ Dates: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Appendectomy    Tonsillectomy    Gall Bladder    Hernia    Back Surgery    Broken bones    Hysterectomy    Ear Tubes

Child Birth    Other: \_\_\_\_\_ In or out Pt. \_\_\_\_\_

Major Accidents or Falls: \_\_\_\_\_ When: \_\_\_\_\_ Treatment: \_\_\_\_\_

Hospitalizations (other than above): \_\_\_\_\_ When: \_\_\_\_\_ Treatment: \_\_\_\_\_

Habits	Heavy	Moderate	Light	None	Date of Last:	Within 2 years
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic Adjustment	<input type="checkbox"/>
Coffee/Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Examination	<input type="checkbox"/>
Pop/Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Exam	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunization	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Test	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest x-ray	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies:	<input type="checkbox"/>
Pain Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to what?	<input type="checkbox"/>

Physical Stress levels (circle: 1=mild to 10=severe)    1 2 3 4 5 6 7 8 9 10    Main Stressor: \_\_\_\_\_

Emotional Stress levels (circle: 1=mild to 10=severe)    1 2 3 4 5 6 7 8 9 10    Main Stressor: \_\_\_\_\_

I hereby authorize Dr. Lubkeman to treat the above conditions.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## AUTHORIZATIONS TO TREAT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

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**Authorization to Treat:** I authorize Dr. Lubkeman or his designee to treat conditions that are presented to him in the course of consultation, examination or care in this clinic. If I am signing this as a parent or guardian of a minor child or other person unable to give consent, I hereby authorize the treatment of said individual by Dr. Lubkeman.

**Acceptance of Financial Responsibility:** I understand that I am personally liable for all charges incurred in this office for services rendered to me or the person I represent. Insurance is an agreement between me and the insurance company. The doctor's office will file and accept payment from insurance as a service to me but I am, ultimately, responsible for any amount the insurance company does not pay including co-pays, deductibles, and insurance denials. If payment is denied or only part of the payment is received due to deductible or other insurance company restriction, I also agree to be responsible for the remaining portion of the billable services accrued as a result of receiving treatment in this clinic. I understand that I am entitled to, as part of this agreement, a complete accounting of all services billed.

Medicare, Medicaid, and other insurance companies only pay for a limited number of adjustments per year. Some insurances', including Medicare do not pay for x-rays when ordered by a chiropractor. Some, including Medicare and Medicaid, do not pay for examinations (which they require before treatment can be authorized) and other therapies in certain situations. The doctor's office will do its best to keep me informed of services performed or to be performed that my insurance does not cover so I can make an educated decision about the necessity of performing these services in your case.

**Authorization to Bill Insurance Companies:** By signing this agreement, I do hereby authorize Arbor Vitae P.C. and Dr. Roy Lubkeman to release any medical or other information necessary to process insurance claims for services rendered in this office. I also request payment of government benefits to Dr. Lubkeman or Arbor Vitae P.C. as the patient and/or insured's designee. (Box 12 & 13 of Form CMS-1500)

**I have read and understand the terms of this agreement. I agree to be personally and fully responsible financially for charges accrued in the course of my treatment in this office. I am over 18 years of age and understand this is a legally binding agreement.**

<hr/>		<i>Dr Roy Lubkeman</i>
<b>Signature</b>	<b>Date</b>	<b>Provider Name</b>
<hr/>		
<b>Patient (if other than signator)</b>	<b>Age</b>	

**Privacy Statement:** Your privacy is important to us and we will take every effort to preserve your privacy and your private information. Health Information is protected under the HIPAA act and we will not release your private information to any unauthorized entity without your written permission/authorization. While the HIPAA laws allow sharing of information between treating physicians without authorization, it is our policy to require a higher standard and require authorization for transmission of information to any other clinical entity. The insurance company and clearinghouse providers are also held to the same privacy standards that apply to all healthcare facilities and providers.