CONFIDENTIAL PATIENT INFORMATION

Please Print

PERSONAL INFORMATION

DATE:_____

Name_____Soc Sec No._____Home Ph_____
Address_____City_____Zip Code_____
Drivers License #_____State_____Cell Ph_____
Age_____Birth Date_____Marital Status: M S W D How Many Children?_____
Occupation_____Employer_____
Address_____Work Phone_____
Name of Wife or Husband_____Occupation_____
Spouse's Employer_____Address_____Ph #_____
Your nearest relative_____Address_____Ph#_____
Referred by_____
So that we may provide you the information you will need regarding our office and your condition, please provide us with your **e-mail address** here:_____

HEALTH HISTORY

Name of Family Physician_____
Date of Last Physical Examination_____Female: Are you pregnant?____
What Operations Have You Had_____
Serious Illness_____
Have You Ever Been Under Chiropractic Care____Yes ____ No Doctor's Name_____

HAVE YOU EVER SUFFERED FROM: (circle each that applies)

Allergy	Poor Posture	Tuberculosis	Difficult Breathing
Dizziness	Sciatica	Bruise Easily	Pleurisy
Fatigue	Spinal Curvature	Hay Fever	Spitting
Headache	Swollen Joints	Nosebleeds	Itching
Loss of Sleep	Colon Trouble	Sinus Infection	Varicose Veins
Ulcers	Diarrhea	High Blood Pressure	Bed Wetting
Numbness	Hemorrhoids	Nervousness/Depression	Difficult Digestion
Arthritis	Low Blood Pressure	Frequent Urination	Pain Over Heart
Bursitis	Poor Circulation	Kidney Infection/Stone	Prostrate Trouble
Foot Trouble	Colds	Slow Heart Beat	Rapid Heart Beat
Nausea	Asthma	Cramps/Backache	Lumps in Breast
Low Back Pain	Deafness	Anemia	Hot Flashes
Stroke	Neck Pain/Stiffness	Ear Noises	Irregular Cycle
Chest Pain	Enlarged Thyroid	Failing Vision	Eye Pain
Diabetes	Alcoholism	Polio	Excessive Menstrual Flow
Cancer	Venereal Disease	Swelling of Ankles	

Tingling or numbness in:

Shoulders	Hips
Arms	Legs
Elbows	Knees
Hands	Feet

Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

What Medications or Home Remedies are you currently taking:

_____

_____

Great Health Chiropractic
The Journey To Great Health Starts with Us
Jeff Bratten, DC, 1155 NE Hogan Drive, Gresham, OR 97030 667-3366

CURRENT COMPLAINTS

Purpose of this appointment (major complaint)_____

_____

Have you been treated for any health conditions by a physician in the last year? _____ yes _____no

Describe_____

Have you lost any days from work due to this condition?_____

Have you attained an attorney for this condition? _____ yes _____ no

Attorney name_____address_____phone#_____

INSURANCE INFORMATION

Personal: Name of insurance company_____Address_____

Phone #_____Group#_____ID#_____

Name of policy holder_____

Auto: Name of insurance company_____Address_____

Phone#_____Policy#_____Claim#_____

Name of policy holder_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment_____

I understand and agree that health and accident insurance polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable unless prior payment arrangements have been made. I understand that a monthly processing charge of 1.25% will be assessed on any past due balance.

I hereby authorize the doctor to treat my condition as he deems appropriate. I also authorize the doctor to use manipulation throughout my spine. It is understood and agreed the amount paid the doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named, for whom I am legally responsible) by Dr. Jeffrey J. Bratten and/or other licensed Doctor of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a back up for Dr. Jeffrey J. Bratten. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms of pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I agree to give this office the right to forward any information regarding my care to any attorney, insurance company, or other doctor if the treating doctor in this office so chooses. I also authorize Great Health Chiropractic to request and attain any and all information from my insurance company, attorney, employer or any physicians regarding this condition.

NOTICE TO PATIENT OF WORKERS' COMPENSATION BILLING PRACTICE

ORS 656.245 (1) entitles an injured worker to all reasonable and necessary medical services that the nature of the injury or the process of recovery requires. Therefore, all medical services provided for an on-the-job injury will first be submitted to the worker's compensation insurer in accordance with the Oregon Administrative Rules governing billing practices.

ORS 656-005 (12) allows a doctor of chiropractic medicine to be the attending physician for a period of 60 days from the date of first visit or for 18 visits, whichever first occurs, on the initial claim. After the 60th day or 18th visit, continued treatment will only be reimbursed by the workers' compensation insurance company if a medical doctor prescribes continued chiropractic treatment and provides a treatment plan to the insurance company prior to the commencement of treatment. Should the workers' compensation insurance company accept the claim for benefits and require the injured worker to participate in a Managed Care Organization (MCO) or the insurer requires the injured worker to participate in an MCO prior to acceptance and guarantees payment of those medical benefits in writing, the injured worker would then be required to see a doctor on the insurance company's preferred doctor list for that MCO.

If a bill that has been submitted to the insurance company on an accepted claim has not been paid within 45 days, or has been submitted and the insurance company has denied payment of the bill, the bill will be forwarded to the patient with an explanation of the insurer's action. The patient may then retain the services of an attorney, whose fees will be paid by the insurance company, which may then request a hearing. No further billings will be submitted to the patient pending the outcome of litigation brought about by the patient's attorney. However, the patient may decide not to request a hearing but will then be responsible for payment of the bill. If the result of the hearing is that the bill is not the responsibility of the workers' compensation insurance company, the bill will be submitted to the patient's health insurance provider to be paid in accordance with the limits, terms and conditions of that policy. IF the patient has no health insurance, the bill(s) will be submitted to the patient as if no worker's compensation claim existed.

By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided by this medical service provider. I further acknowledge that, based on the above, I may be responsible for the payment of the services provided by this provider. By providing us with your email address you are giving us permission to communicate to you by email..

*Date*_____*Patient Signature*_____