Centerpointe Chiropractic & Physical Therapy

4085 North Jefferson St, Medina, OH 44256

PATIENT HISTORY

Date________________

Name____Age_____Date of Birth_________________

Address____

City____State_________________Zip_____________

Social Security Number_________________________E-Mail____

Phone_________________________Work Phone_________________________Other_________________

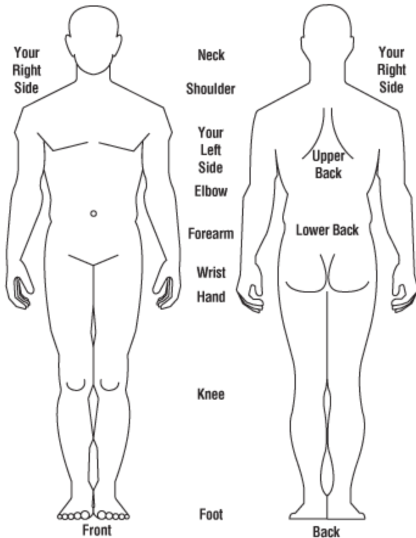
Are you: Married_____ Single_____Divorced_____Widowed_____Name of Spouse_________________

Nearest relatives name & phone number?____

Name of insured employer____

How will payment be made?

Health Insurance_____ Self-pay_____Auto Insurance_____Worker's Comp. ___Claim #_______________



Mark & describe your major complaint

____

____

How did this condition develop?

____

____

When was the first time you were aware of this problem?

____

____

Have you ever had this problem or a similar problem before? If yes, please explain.

____

____

Has this problem been getting better, worse, or staying the same?____

Name of Primary Care Physician______________________________________Phone____________________

Address____

HEALTH HISTORY

Current Medications____

____

Known Allergies____

Describe and personal history of surgeries, cancer, serious illnesses, or pre-existing conditions_________

____

____

Describe any family history of cancer, diabetes, stroke, heart conditions, or other____________________

____

Please complete reverse side

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Check below if you have a history of or currently have:

___ Alcohol addiction ___Diabetes ___High blood pressure ___Stroke ___Seizure

___Drug addiction ___Birth control pills ___Bowel dysfunction ___Bladder dysfunction

___Unexplained cough ___Unexplained weight gain ___Smoking___packs per day

Are you pregnant? Yes___No___ Number of deliveries_______

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize B. Lou Rossi, DC and Kyle Milligan, PT and whomever they may designate as their assistants to administer Chiropractic/Physical Therapy care as they deem necessary to my son/daughter.

Parent/Guardian Signature:____

ASSIGNMENT/INSTRUCTION FOR DIRECT PAYMENT TO THE DOCTOR

I, hereby instruct my insurance company to pay directly to: CENTERPOINTE CHIROPRACTIC & PHYSICAL THERAPY, 4085 NORTH JEFFERSON ST. MEDINA, OH 44256. Or if my current policy prohibits direct payment to the Doctor, I hereby instruct and direct you to make out the check and mail it to the above address the professional or medical expense benefits allowable, and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under the policy.

This payment will not exceed my indebtedness to the above named assignee and I have agreed to pay, in a current manner, an insurance payment. A photocopy of this assignment shall be considered as valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case. If the insurance company is uncooperative, I authorize CENTERPOINTE CHIROPRACTIC & PHYSICAL THERAPY to submit a complaint to the insurance commissioner.

HEALTH INSURANCE CLAIM FORM 1500

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services. [i]

I acknowledge that the above information is true and that I have read and agree to all of the above.

_______________________________________ _______________________

Printed Name Date

____

Signed Name