IPMD
INTEGRATIVE PHYSICAL MEDICINE OF DAYTON

GENERAL INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Phone#: _____

City, State, Zip: _____ Birth Date: _____ / _____ / _____

Email Address: _____ Social Security #: _____ - _____ - _____

Occupation: _____ Employer Name: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like to be set up on automatic text reminders? [ ] Yes [ ] No If yes, who is your cell phone provider? _____

How were you referred to our office? [ ] By an attorney [ ] By a doctor [ ] By a patient [ ] Someone from our office [ ] Internet search [ ] By your health insurance [ ] Drive-by [ ] Other; Please specify: _____

ACCIDENT INFORMATION

Is this visit due to an accident? [ ] Yes [ ] No If yes, what type? [ ] Auto [ ] Work [ ] Other Date of Accident _____

Has the accident been reported? [ ] Yes [ ] No To Whom? _____ Claim Number_____

HEALTH INSURANCE INFORMATION

Name of ***Your Health Insurance Co***._____

Policy # _____ Group # _____

Insured's Name if different than yours _____ Insured's SS# _____/_____/_____

Relationship to Insured _____ Insured's Birth date _____/_____/_____ Employer_____

SECONDARY INSURANCE INFORMATION

Name of ***Your Health Insurance Co***._____

Policy # _____ Group # _____

Insured's Name if different than yours _____ Insured's SS# _____/_____/_____

Relationship to Insured _____ Insured's Birth date _____/_____/_____ Employer_____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Signature of Patient/or Guardian of said Minor _____ Date _____

HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Asthma
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Sleeping Difficulties
- ❑ Loss of Smell
- ❑ Allergies
- ❑ Blurred Vision
- ❑ Light Bothers Eyes
- ❑ Depression
- ❑ Nervousness
- ❑ Tension
- ❑ Cold Sweats
- ❑ Stomach Problems
- ❑ Night Pain
- ❑ Sudden Weight Loss
- ❑ Loss of Taste
- ❑ Loss of Memory
- ❑ Jaw Problems
- ❑ Constipation
- ❑ Shortness of Breath
- ❑ Bowel/Bladder Changes
- ❑ Nausea
- ❑ Cold Feet
- ❑ Chest Pain
- ❑ Fever
- ❑ Fainting
- ❑ Eczema

Please check to indicate if you have ever had any of the following:

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other_____

_____

_____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain _____

Please list any medications you are currently taking (Be sure to include dosage and frequency) _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date) _____

_____

Please list any supplements you are currently taking (vitamins, minerals, herbs)_____

Are you currently on any blood thinners – (aspirin regimen included)? ☐ Yes ☐ No List Type _____

Contraindications: A few procedures in the office should be avoided if patients have certain conditions.

Please CHECK if you have any of the following:

☐ A pacemaker ☐ Suffer from blood clots ☐ Knee/ hip replacement ☐ Local or systemic infection ☐ Egg allergy

☐ Corticosteroid or Local Anesthetic Allergy ☐ Additional allergies (please list) _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease _____ ☐ Diabetes _____ ☐ Other _____

☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

Do you exercise?: ☐ Yes ☐ No How often?: 1X 2X 3X 4X 5X per week Other: _____

Which activities: ☐ Running ☐ Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ Other _____

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine_____ cups/day Alcohol _____ drinks/week Energy Drinks_____ cups/day Cigarettes_____ packs/day

I hereby certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient's / Guardian's Signature_____ Date_____

Doctor Reviewed Signature _____ Date_____

Doctor Updated Signature _____ Date_____

POLICIES, RELEASES AND FINANCIAL RESPONSIBILITY

1.) I understand that payment is due at the time of service unless we contracted with your insurance company, or you make other arrangements with our office.
2.) I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. Please refer to our Insurance Company Payment Policy. It can be found on our website at www.ipmdohio.com.
3.) I understand in the event my account goes to collections, I am responsible for any and all collections fees.
4.) Patients are required to notify IPMD of any changes to their insurance and demographics. IPMD is not responsible for any denials for inaccurate insurance information.
5.) I clearly understand that if I terminate my care prematurely that all fees incurred will be due and payable at that time.
6.) I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
7.) I consent to treatment necessary for the care of the individual named below.
8.) IPMD will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. Please refer to the Authorization of Care. It can be found on our website at www.impdohio.com.
9.) If you are unable to make your scheduled appointment, and we are not notified in advance, you may be charged a $20 cancellation fee. (Please refer to our appointment policy for further explanation by visiting www.impdohio.com). _____**Initial**
10.) I understand I have certain rights regarding my protected health information and I authorize Integrative Physical Medicine of Dayton, LLC to disclose that information to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for more information. It can be found at www.ipmdohio.com. _____ **Initial**

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

RADIOGRAPH CONSENT

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition.

By signing below, you give your consent to allow Integrative Physical Medicine of Dayton, LLC and its representatives, as deemed by the examining physician to take radiographs of your spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____