



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? _____

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 symptoms:

- | | | | | |
|---|---|---|--|---------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of
Breath | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Blurred Vision | | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Leg/Knee Pain | | | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Pins/Needles in Arms | | | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Pins/Needles in Legs | | | <input type="checkbox"/> Problem Urinating | |

Please check to indicate if you have ever been diagnosed with any of the following:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Migraines | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures _____ | <input type="checkbox"/> High Blood
Pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| | <input type="checkbox"/> Heart Disease | | | <input type="checkbox"/> 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 _____

Please list any surgeries you have had _____

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:

- | | | | | |
|---|--|--|--|--------------------------------------|
| <input type="checkbox"/> A pacemaker | <input type="checkbox"/> Suffer from blood clots | <input type="checkbox"/> Knee/ hip replacement | <input type="checkbox"/> Local or systemic infection | <input type="checkbox"/> Egg allergy |
| <input type="checkbox"/> Corticosteroid or Local Anesthetic Allergy | <input type="checkbox"/> Allergies (please list) _____ | | | |

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

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |

What is your daily/weekly intake of the following:

Alcohol _____ drinks/week Cigarettes _____ packs/day Recreational Drugs _____

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 _____

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.ipmdohio.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.ipmdohio.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
- 11.) I understand that strokes are a very rare event in the general population and have been reported after patients visit Chiropractors or primary care providers (medical doctors). Scientific evidence shows that the increased stroke risks are likely due to patients seeking care from Chiropractors or medical doctors because of an unusual type or severity of headache and neck pain. These symptoms are from an early stroke that is already occurring and progressing from prior damage to an artery in the neck. Once seen by a doctor, the risk of the stroke progressing has been found in the literature to be similar (no excessive risk) for patients who are seen by Chiropractors and Primary Care Providers. There is scientific evidence that shows that patients who have these developing strokes may have weakened or diseased artery vessel walls that are particularly vulnerable to a variety of motions or movements of the neck and head or they may occur spontaneously without any known reason. Research has shown that there are many stroke risk factors, including: disease of blood vessels, high blood pressure, birth control pills, environmental and genetic factors, infections, occurring during falls, violent car accidents, coughing/sneezing, sport activities, or even during such trivial movements as turning ones head to back up a car or to paint a ceiling. The literature shows that there are rare risks of strokes specifically from rotating and extending the head and neck during the physical examination, from cervical spine manipulation or other maneuvers that rotate or extend the head and neck, particularly the upper cervical spine. You are being informed of this reported association because a stroke may cause serious injury or even death. _____ 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** _____