PC MEDICAL CENTERS
JOINT AND SPINE EXPERTS

New Patient Form

Date

Month Day Year

Email *

example@example.com

Name *

First Name Last Name

Age *

Date of Birth *

Month Day Year

Address *

Street Address

Street Address Line 2

Phone Number *

Please enter a valid phone number.

Social Security Number *

Employer *

Marital Status *

Spouses Name

Spouse's Phone Number

Please enter a valid phone number.

Insured Name (Only if different from above)

First Name Last Name

Insured SSN (Only if different from above)

Insured DOB (Only if different from above)

Month Day Year

Guarantor Name (Only if different from above)

First Name Last Name

Guarantor SSN (Only if different from above)

Guarantor DOB (Only if different from above)

Month Day Year

Guarantor Address (Only if different from above)

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Who referred you to this office?

Referred by:

Are your complaints related to an accident? *

- ☐ Yes
- ☐ No

Date of accident:

Month Day Year

If this is an accident or work related injury, please ask the receptionist for additional forms.

PAYMENT POLICIES FOR MEDICAL PRACTICE

We accept cash, check, Visa, Mastercard, Discover Card, Care Credit and most insurance companies.

If you have insurance, the following apply:

1. It is your responsibility to provide us with the correct information about your insurance company and to follow the rules of your insurance company. 2. You are responsible for paying any deductibles, co-payments or non-covered services. 3. We file group insurance claims. If your insurance company does not approve treatment, you will be responsible for the charged services. In the event of non-payment, you will be responsible for any collec and/or legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.

I have read all the above terms and hereby assume responsibility for paying any charges according to these terms.

Date *

Month Day Year

CONSENT FOR TREATMENT, AUTHORIZATION FOR RELEASE OF INFORMATION, AND AUTHORIZATION FOR PAYMENT

CONSENT FOR TREATMENT:

The undersigned hereby consents to standard treatment and routine medical and nursing procedures. I understand this may include, but is not limited to, measurements and procedures to determine the cause of the problem, movement of my spinal vertebrae using hands or instruments designed for this purpose, mild electrical and sound-wave stimulation of the skin surfaces and muscles.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize PC Medical Centers and its designated staff to make records about my personal and physical condition and to maintain this information electronically, by fax transmission, by voice telephone, or by mail. Any and all information contained in my medical records pertaining to a specified period of treatment to my family physician or consulting physician or other healthcare professionals or to my

insurance company. I understand PC Medical Centers keeps on file notice of their policies regarding the use of my personal health information and that I may review those policies upon my request. I understand that this must be provided in writing to PC Medical Centers.

AUTHORIZATION FOR PAYMENT:

I hereby authorize PC Medical Centers to receive medical insurance benefits otherwise payable to me for services rendered but not to exceed the balance due of the regular charges provided me for and during this period of treatment. I understand that it is my responsibility to provide PC Medical Centers with timely notification of my insurance coverage. I understand that I am financially responsible to PC Medical Centers for charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original and direct payment of medical insurance benefits directly to PC Medical Centers. In consideration of the services to be rendered I agree to pay for services charged at PC Medical Centers office not paid for by my insurance benefits in accordance with its regular rates and charges for services and goods. Should the account become delinquent and be referred to a collection agency or attorney, I shall pay all reasonable collection expenses, court costs and a reasonable attorney fee.

Any exceptions to this consent, if any: (If none, write "none") *

Date *

Month Day Year

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review carefully. We are required by the Health Insurance Portability & Accountability Act of 1996 (HIPPA) to provide confidentiality for all medical/mental records and other individually identifiable health information in our possession. This notice is to inform you of the uses and disclosures of confidential information that may be made by PC Medical Centers and of your individual rights at PC Medical Centers legal duties with respect to confidential information.

Ways in which we may use and disclose your protected health information:

We may use an disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and health care options.

Treatment:

Means providing, coordinating or managing health care and related services.

Payment:

Means activities such as obtaining payment for the services provided to you.

Health Care Options:

Includes day to day operations regarding you within this practice. We may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose our protected health information to individuals you identify as involved in payment with your care. We will use and disclose your protected health information when required by federal, state, or local law. There are certain situations in health care that may arise where this office is ethically and legally mandated to reveal your protected health information to appropriate persons or agencies even if you do not give permission. These situations include a.) if you threaten bodily harm or death to yourself or another person; b.) if you report your knowledge of physical or sexual abuse of a minor or child, or of an elder over age 65; c.) if we are requested by a court of law to turn over records to the court or if we are ordered to testify regarding those records. Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing at any time and will be honored to the extent that any actions that have already occurred regarding your authorization.

Your signature below indicates you have read and understand the above information regarding protected health information uses and disclosures.

Date *

Month Day Year

Name *

First Name Last Name

Date of Birth *

Month Day Year

Chief Complaint: *

History of present illness:

Location of Problem: (Where is the pain/problem?) *

How severe is the pain/problem with 10 being the worst? *

	1	2	3	4	5	6	7	8	9	10	
Least Severe	○	○	○	○	○	○	○	○	○	○	Most Severe

Does the pain occur at a specific time? *

What other areas of your body are affected by this problem? *

- ☐ Head/Neck
- ☐ Shoulders/Arms
- ☐ Upper Back
- ☐ Lower Back
- ☐ Hips
- ☐ Wrists/Hands
- ☐ Legs
- ☐ Knees
- ☐ Ankle/Feet
- ☐ None
- ☐

Are you on any medication for this problem now? *

What have you tried in the past to handle this problem? *

- ☐ Heat
- ☐ Ice
- ☐ Over The Counter Medication
- ☐ Prescription Medication
- ☐ Rest
- ☐ Exercise
- ☐ Physical Therapy
- ☐ Chiropractic

- [ ] Massage
- [ ] None

How long have you had this pain/problem? When did it start? *

What activities have you given up on due to this pain/problem? (Example: Stopped climbing stairs as much.) *

What activities increase symptoms/makes your problem worse? *

Past medical history: (Please select if you have ever had any of the following) *

- [ ] Measles
- [ ] Hepatitis
- [ ] Mumps
- [ ] Chicken Pox
- [ ] Whooping Cough
- [ ] Thyroid Disease
- [ ] Scarlet Fever
- [ ] Diphtheria
- [ ] Small Pox
- [ ] Pneumonia
- [ ] Rheumatic Fever
- [ ] Arthritis
- [ ] Venereal Disease
- [ ] Anemia
- [ ] Ulcer
- [ ] Bladder Infection
- [ ] Epilepsy
- [ ] Migraines
- [ ] Bleeding Tendency
- [ ] Tuberculosis
- [ ] Diabetes
- [ ] Cancer
- [ ] Polio
- [ ] Glaucoma
- [ ] Hernia
- [ ] Blood Transfusion

- [ ] Back Trouble
- [ ] Kidney Disease
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Hemorrhoids
- [ ] Asthma
- [ ] Hives of Eczema
- [ ] AIDS & HIV
- [ ] Infectious Mono
- [ ] Bronchitis
- [ ] Mitral Valve Prolapse
- [ ] None
- [ ] Other

Date of last chest X-Ray:

Any other medical conditions or diagnosis not listed?

Medications: (Include non-prescription and prescription)

Primary Care Physician: *

Have you ever taken Fen-Phen/Redux? *

- ○ Yes
- ○ No

Are you taking any medications for acid indigestion? (Prescription and OTC) *

- ○ Yes
- ○ No

If yes, please list acid indigestion medications:

Allergies/Medication allerigies:

Do you have a sulfa allergy? *

- ○ Yes
- ○ No
- ○ Unsure

Use of alcohol: *

- ○ Never
- ○ Rarely
- ○ Moderate
- ○ Daily

Use of Tobacco: *

- ○ Never
- ○ Rarely
- ○ Moderate
- ○ Daily

Use of Drugs: *

- ○ Never
- ○ Rarely
- ○ Moderate
- ○ Daily

Excessive Exposure (At home or at work) to any of the following: *

- ☐ Fumes
- ☐ Dust
- ☐ Solvents
- ☐ Airborne Particles
- ☐ Noise
- ☐ N/A

Family Medical History:

Indicate which of the below you have experienced in the last 1-2 months.

1=Never 2=Rarely 3=Occasionally 4=Frequently 5=Constantly

Muscle Aches *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Fibromyalgia *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Arthritis *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Joint Pain *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Low Back Pain *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Neck Pain *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Wrist/Hand Pain *

1 2 3 4 5

○ ○ ○ ○ ○

Elbow Pain *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Shoulder Pain *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Hip Pain *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Knee Pain *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Ankle/Foot Pain *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Pain Between Shoulder Blades *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Headaches *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Migraines *

1 2 3 4 5

Never ○ ○ ○ ○ ○ Constantly

Dizziness *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Numbness *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Tingling In The Hands or Feet *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Pins/Needles in Hands or Feet *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Burning in Hands or Feet *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Hypersensitivity *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Difficulty With Balance

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Fatigue *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Malaise *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Weakness, Tiredness *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Lightheadedness *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Irritability *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Constipation *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Diarrhea *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Feeling Foggy *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Forgetfulness *

	1	2	3	4	5	
Never	○	○	○	○	○	Constantly

Do you have a living will? *

- ○ Yes
- ○ No

Do you have a DNR (do not resuscitate)? IF YES, please provide the office with a copy. *

- ○ Yes
- ○ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Date *

Month Day Year

Date

Month Day Year