Confidential New Patient Information

Print Name _____ Date _____

Name you would like to be called _____

Email _____

Street Address_____

City _____ State _____ Zip _____

Cell # _____ Home # _____ Work # _____

Date of Birth _____ Age _____Social Security # _____

Your Occupation _____ Work Duties _____

How did you hear about the office? _____

Marital Status Married _____ Single _____ Divorced _____ Widowed_____

Sex Male_____ Female_____

Number of children _____ Age of children _____

Emergency Contact

Name _____ Relationship _____

Cell # _____ Home # _____

Insurance Information

If you have insurance information please provide the staff with your card.

Insurance Patients I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. Please make payment for your portion of charges at each visit unless other arrangements are made.

Patient's Signature _____ Date _____

Patients Without Insurance Please pay for services at the time of each visit. We accept Visa, MasterCard, checks or cash. If you prefer, a payment plan will be set up for your convenience.
Let us know which one you prefer. (check one) _____ Payment at time of service _____ Payment Plan

Patient's Signature _____ Date _____
(signature of parent or guardian if the patient is a minor)

Name _____ Date _____

Medical History – Section 1

Height _____ Weight_____

Have you ever been to a Chiropractor before? YES_____ NO_____

If YES Doctor's Name: _____

Date of last Chiropractic visit: _____ Reason for Care: _____

Who is your Primary Care Physician _____Phone # _____

List any Conditions you are currently being treated for: _____

FEMALES ONLY: Is there a possibility you are pregnant? YES_____ NO_____

Have you had a DEXA Scan? YES_____ NO_____ If so, when? _____

Have you had a Vitamin D Test? YES_____ NO_____

Smoking _____Current Every Day Smoker _____ Current Some Days Smoker

_____Former Smoker (> than 100 Cigarettes in Lifetime) _____Never Smoked

Please check if you have had or currently have

Fractures _____ Osteopenia _____ Osteoporosis_____

Heart Problems _____ Cancer _____ Blood Disorder/Clotting_____

If you have had the following, or if you suffer from the following, please Check!

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally	Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	___	___	Nervousness	___	___
Migraines	___	___	Vision Changes	___	___
Neck Pain	___	___	Nose Bleeds	___	___
Shoulder Pain	___	___	Ringing in Ears	___	___
Arm/Hand Pain	___	___	Earaches	___	___
Mid Back Pain	___	___	Hearing Loss	___	___
Low Back Pain	___	___	Cough	___	___
Hip Pain	___	___	Chest Pains	___	___
Leg/Foot Pain	___	___	Female Problems	___	___
Disc Problems	___	___	Insomnia	___	___
Arthritis	___	___	Asthma	___	___
Other Joint Pain	___	___	Fatigue	___	___
Numbness	___	___	Frequent Colds	___	___
Joint Swelling	___	___	Diabetes	___	___
Dizziness	___	___	Hypoglycemia	___	___
Nausea	___	___	Digestive Problem	___	___

Name_____Date_____

Medical History – Section 2

Medications YES_____ NO_____ If YES, please list current medication(s) prescription and over-the-counter

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Drug Allergies YES _____ NO _____ If YES, please list below

1. _____ 2. _____

Surgeries YES _____ NO _____ If YES, please list type and date

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Accidents YES _____ NO _____ If YES, please list type and date

1. _____ 3. _____
2. _____ 4. _____

Other Medical History _____

_____

_____

_____

In general would you say your health is? (circle your answer)

1 - Excellent 2- Very Good 3 - Good 4 - Fair 5 – Poor

Compared to one year ago, how would you rate your health in general? (circle your answer)

1 - Much better 2 - Somewhat better 3 - About the same 4 - Somewhat worse 5 - Much worse

Motor Vehicle Crash History

Please Print

Patient Name _____ Date _____

1. Date of Crash: _____Time of Day: _____ Road Condition: ___ Dry ___ Wet
2. Were you: ___ Driver ___ Passenger ___ Front Seat ___ Back Seat
3. Number of people in your vehicle? _____
4. Were you wearing a seat belt? ___ Y ___ N (If no, Skip the next question)
5. If yes, were you wearing a lap belt? ___ Y ___ N Lap belt and shoulder harness? ___ Y ___ N
6. What direction were you headed? ___ North ___ South ___ East ___ West

If you are not sure, leave direction questions blank.

On (name of street and city): _____

7. What direction was the other vehicle headed? ___ North ___ South ___ East ___ West

On (name of street and city): _____

8. Were you struck from: ___ Behind ___ Front ___ Left Side ___ Right Side

Other combination, please describe: _____

9. What was the position of your head during the crash?

___ Straight Ahead ___ Turned Right ___ Turned ___ Left ___ Other

10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, etc)? ___ Y ___ N

If yes, please explain: _____

11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)? ___ Y ___ N

If yes, please describe: _____

12. If your vehicle was equipped with air bags, did they activate? ___ Y ___ N
13. Make/model of your car: Make/model of the other vehicle: _____
14. Were the police notified? ___ Y ___ N Please provide this office with a copy of the police report.
15. In your own words, please describe the accident:

_____

_____

16. Did you have any physical complaints BEFORE the accident? ___ Y ___ N

If yes, please describe in detail:

_____

_____

_____

17. Please describe how you felt: _____

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

18. Did you lose consciousness during the crash? ___ Y ___ N If yes, for how long? _____

19. Where were you taken after the accident? _____

20. Have you been treated by another doctor since this accident? ___ Y ___ N

If yes, please list the doctor's name and address: _____

What type of treatment did you receive? _____

21. Did this accident occur while you were performing your regular job duties? ___ Y ___ N

22. How do you feel now, what is your number-one problem or the one area of greatest pain? _____

23. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**

24. Since this injury occurred, is your pain: ___ Improving ___ Getting Worse ___Staying the Same

25. How often do you experience the pain?

___ 1-2 hours per day ___ About half of the day ___Most of the day ___ The pain never goes away

26. How does the pain affect your daily activities?

___ It does not affect my daily activities ___ I have had to change how I do things

___ I have had to stop doing some of my daily activities ___ I am unable to perform daily activities

27. What increases your pain? _____

28. What decreases your pain? _____

29. Have you ever experienced this problem before? ___ Y ___ N When? _____

30. Do you have a previous illness/disease which affects your present condition? ___ Y ___ N If yes, please describe:

_____

31. List any other complaints currently bothering you and rate your pain level for each.

a. _____0 1 2 3 4 5 6 7 8 9 10
b. _____0 1 2 3 4 5 6 7 8 9 10
c. _____0 1 2 3 4 5 6 7 8 9 10
d. _____0 1 2 3 4 5 6 7 8 9 10

32. Have you lost time from work as a result of this accident? __ Y ___ N

a. Type of employment: _____

b. Last day worked: _____

33. Have you ever been involved in an accident before? ___ Y ___ N

a. If yes, when? _____

b. Describe the accident(s): _____

c . Were you injured? ___ Y ___ N Explain: _____

34. List all medication you are currently taking (prescribed and over the counter) _____

35. List all surgeries you have had (with date) _____

If you have experienced any of the following conditions in the **past** mark a **"P"** on the line provided. If you are **currently experiencing** any of the following conditions please mark a **"C"** on the line provided. (check all that apply)

___ heart attack	___ stroke	___ arthritis	___ gall bladder trouble
___ diabetes	___ glaucoma	___ fainting spells	___ kidney stones
___ difficulty with urination	___ bloody stools	___ difficulty with bowel movements	
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ AIDS	___ ulcers	___ diverticulosis	___ menstrual cramping
___ dizziness	___ loss of memory	___chest pain	___ shortness of breath
___constipation	___ diarrhea	___ general fatigue	___ sudden weight loss
___ nausea	___ muscle cramping	___ soreness in joints	___ loss of hearing
___ ears ringing	___ headache	___ migraine	___ epilepsy
___ gout	___ tuberculosis	___ syphilis	___ sprained ankle R L
___ knee/hip replacement		___ broken bones (specify) _____	

General Activities (check all that apply)

___ sleep on waterbed	___ read in bed	___ fall asleep in recliner/on couch
___ sleep on stomach	___ use two or more pillows to sleep with	
___ needlepoint/knitting	___ sewing	
___ lift weights/wt. mach.	___ play video games (___ hrs per day)	
___ exercise ____x/wk	___ jog ___ x/wk	___ computer use (___ hrs per day)
___ swim	___ use elliptical	___ watch television (___ hrs per day)

Please add anything else you would like the doctor to know:

_____

_____

_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____
(signature of parent if the patient is a minor)

Insurance Information

Vehicle you were in	Other Vehicle Information
Insured_____	Insured_____
Auto Ins. Co._____	Auto Ins. Co._____
Insurance Phone #_____	Insurance Phone #_____
Adjustor _____	Adjustor_____
Adjustor Phone #_____	Adjustor Phone #_____

Have you retained an attorney? Yes No Date Retained_____

Attorney's Name_____ Phone #_____

Address _____City_____State_____Zip_____

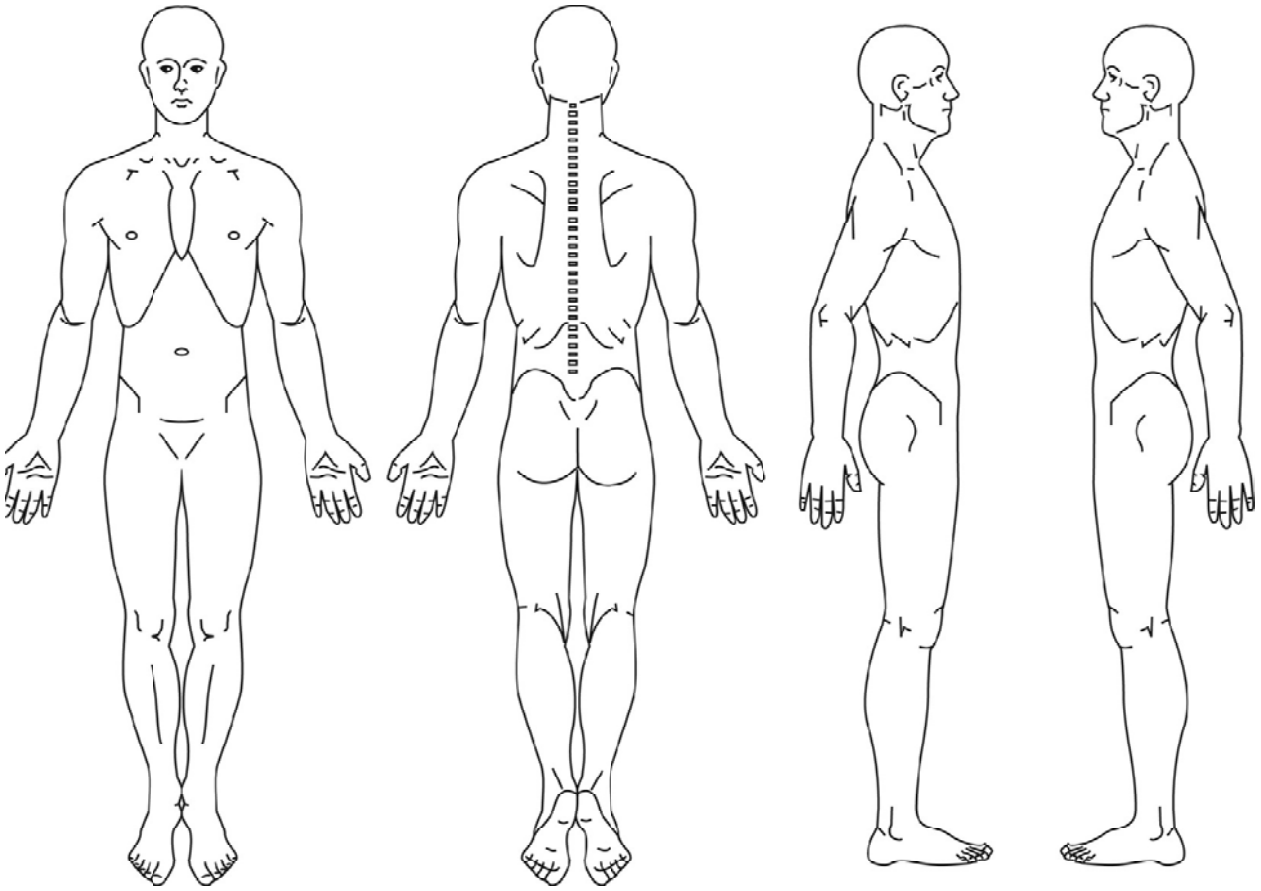
Pain Diagram

Please Print

Patient Name: _____ **Date:** _____

Please complete the following "Pain Diagram" by using the letters below to indicate on the diagram your areas of pain:

(P) Pain **(T) Tingling** **(N) Numbness** **(B) Burning** **(S) Stiffness**



Notes:

_____

_____

_____

_____

_____

_____

LIEN LETTER

Date_____

Patient Name: _____

Patient Address:_____

Claim #:_____

Insurance Company (paying bill):_____

Adjuster's Name: _____

To Whom It May Concern:

I hereby instruct and direct_____Insurance Company or Attorney to pay by check made out and mailed to:

Dr. Brenda L. Kingen, D.C., F.I.A.C.A.
2001 S. Hanley, Suite 220
Brentwood, MO. 63144

If the current policy prohibits direct payment to said doctor, I hereby also instruct and direct you to make out the check to me and mail as follows:

Dr. Brenda L. Kingen, D.C., F.I.A.C.A.
2001 S. Hanley, Suite 220
Brentwood, MO. 63144

For professional or medical expense benefits allowed and otherwise payable to me under the current policy involved as payment toward the total charges for professional services rendered. THIS IS A DIRECT LIEN AND ASSIGNMENT OF MY RIGHTS AND BENEFITS. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said professional services charged over and above this insurance payment.

A photocopy of this Lien/Assignment shall be considered as effective and valid as the original documents.

I authorize the release of any information pertinent to my case to any Insurance Company, Adjuster, and/or Attorney involved in this case.

I authorize Dr. Brenda L. Kingen, D.C., F.I.A.C.A., to initiate a complaint to the Insurance Company for any reason on my behalf.

PATIENT/CLAIMANT SIGNATURE: _____

WITNESS: _____

Financial Policy

It is the goal of this office to provide you the FINEST QUALITY CHIROPRACTIC CARE available. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

- I hereby acknowledge and understand that **all** charges incurred at Kingen Chiropractic Wellness Center are my responsibility.
- Kingen Chiropractic Wellness Center reserves the right to apply a service charge on all delinquent amounts more than 90 days past due. This fee will be computed at a rate of 1 1/2 % per month, 18% annum. This includes all personal injury and/or worker's compensation cases not settled within 90 days after the case is closed.
- In the event it becomes necessary for Kingen Chiropractic Wellness Center or it's agents to employ legal and/or collection counsel, I understand and agree I am responsible for payment of all collections and attorney's fees, which will be added to my account/bill.
- All returned checks will be charged a twenty-five dollar service fee, plus any additional fees (i.e. bank fees, collection fees, etc…).
- There will also be a missed appointment fee of $15.00.

I have read and understand everything described in the Financial Policy, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Individual (Printed)	Signature of Individual
_____	_____
Signature of Legal Representative	Relationship
_____	_____
Witness	Date Signed

Patient Acknowledgement
For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The practice's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out it's healthcare operations. The practice has further explained my right to obtain a copy of this Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The practice's "Notice of Privacy Practices:" is also provided **in the patient bookcase** and on the practice's web site at www.kingenchiropractic.com I may also request a copy from this office at any time via USPS, but will be personally responsible for copy fees and any postage due.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected healthcare information.

I have read and understand everything described in the Patient Acknowledgement (PHI), and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Individual (Printed)	Signature of Individual
_____	_____
Signature of Legal Representative	Relationship
_____	_____
Witness	Date Signed

TERMS OF ACCEPTANCE
Kingen Chiropractic Wellness Center

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I,_____have read and fully understand the above statements.
(*print name*)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(*name*) (*date*)

Consent to evaluate and adjust a minor child

I,_____being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:_____

_____ _____
(*signature*) (*date*)