

Frost Chiropractic

Dr. David Frost, D.C

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NAME: _____ DATE: _____

HOW DID YOU HEAR ABOUT US?

AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK #: _____ HOME #: _____

CELL #: _____

E-MAIL ADDRESS _____

SOCIAL SECURITY #: _____ --- _____ --- _____

OCCUPATION: _____

EMPLOYER: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW PARTNER

SPOUSE'S NAME: _____

IN CASE OF EMERGENCY

CONTACT: _____

RELATIONSHIP: _____

PHONE#: _____

HEALTH INSURANCE

COMPANY: _____

POLICY HOLDER: _____

POLICY #: _____

Reason for visit: _____

WHEN DID YOUR SYMPTOMS APPEAR? _____

RATE THE SEVERITY OF YOUR PAIN ON A SCALE OF 1(LEAST PAIN) TO 10(SEVERE PAIN) _____

TYPE OF PAIN: (Please circle all that apply)

SHARP DULL TINGLING THROBBING NUMBNESS ACHING SHOOTING
BURNING CRAMPING STIFFNESS SWELLING OTHER _____

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM: (Please circle all that apply)

SITTING STANDING WALKING BENDING LYING DOWN

WHAT TREATMENT HAVE YOU RECEIVED FOR THIS CONDITION?

Chiropractic physical therapy surgery none other _____

Name and Address of doctors who have treated your condition _____

Last date of the following:

Physical exam _____ Dental exam _____

X-rays _____ MRI/CT Scan _____

Injuries/Surgery

Falls _____ Date _____

Head Injuries _____ Date _____

Broken Bones _____ Date _____

Dislocations _____ Date _____

Surgeries _____ Date _____

Are you currently taking any medications? No Yes

IF YES, WHAT MEDICATIONS? _____

Do you have any allergies? No Yes

If yes, what are your allergies? _____

Work Activity (Please circle all that apply)

Sitting Standing Light labor Heavy labor

Exercise

None Moderate Daily Heavy

Habits

Coffee/Caffeine Drinks No Yes Cups/Day: _____
Smoking/Tobacco Intake No Yes Packs/Day _____
Alcohol No Yes Drinks/Week _____
High Stress level No Yes Reason _____

HEALTH HISTORY

- AIDS/HIV
- Alcoholism
- Allergy Shots
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lumps
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herniated Disk
- Herpes
- High Cholesterol
- Kidney Disease
- Liver
- Measles
- Migraines
- Miscarriages
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Osteoporosis
- Pacemaker
- Parkinson's Disease
- Pinched nerve
- Polio
- Prostate Problems
- Prosthesis
- Psychiatric Care
- Rheumatoid Arthritis
- Stroke
- Suicide Attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Tumors, Growths
- Ulcers
- Vaginal Infections
- Venereal Disease
- Whooping Cough
- Other _____

ALL PATIENTS NEED TO READ AND INITIAL ALL THAT APPLY:

_____ **PAYMENTS:** Payments are due at the time of each visit. We accept cash, checks and credit cards.

_____ **PAST DUE ACCOUNTS:** Payments over 30 days due are subject to a \$2.00 statement fee per each monthly statement thereafter until balance is paid.

_____ **GENERAL INSURANCE:** The doctor in this office is a participating _____ Provider. When verification has been completed, we will accept assignment as specified for your particular plan. Patients are responsible for all **deductibles, co-payments, and non-covered services**. I understand that any service the doctor is not contracted for will be paid by me. Patients are responsible for payment at the time of each visit. Billing insurance is a convenience that we offer our patients. Most insurance companies process payment in a timely manner of less than 60 days. However, an insurance company may sometimes take 90 days or longer to process payments.

_____ **MEDICARE:** The doctor in this office is a participating Medicare provider. Medicare recipients must present their enrollment cards at the onset of treatment. Medicare requires a \$124 annual deductible to be paid before services are covered. In compliance with the Federal MAAC regulations, the fee for spinal manipulation has been set at \$40. Spinal Manipulation is the only service covered by Medicare. If the patient does not have a second insurance or the second insurance does not cover the treatment, the patient will be required to pay a copayment. Patients are also responsible for any non-covered services.

_____ **CANCELLATIONS:** If you are unable to keep an appointment, we ask that you kindly provide us with at least 24 hours notice. We ask for this advance notice so that we can offer this appointment to another patient.

_____ **RETURNED CHECKS:** There is a \$20 charge for any returned or bounced checks.

_____ **I understand and agree:** that all fees for professional services rendered in my behalf are my personal responsibility and are due and payable at the time of services rendered. I understand that any fees not paid by the insurance company will be paid directly by me upon notification. I hereby authorize and direct Dr. David Frost to release all medical information necessary to process this claim.

I, _____ **authorize Frost Chiropractic to charge my credit card or checking account (check one) for any unpaid fees not paid by the insurance within 60 days.**

Patient's or Guardian's Signature: _____ **Date:** _____

MasterCard **Visa** **Discover** **American Express**
Account # _____ **Exp:** _____
Checking Account # _____
Routing # _____

_____ **I hereby authorize & direct:** the insurance carrier to pay all benefits, which may be due to me according to the policy, directly to Dr. David Frost, D.C. of Frost Chiropractic, to be applied towards my account.

Patient/Guardian's Signature: _____ **Date:** _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties 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 wellbeing, 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 or condition other than vertebral subluxation. However, if during the course of 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.

CONSENT TO TREAT A MINOR

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

Parent/Guardian Signature x _____