PATIENT APPLICATION FORM
WELCOME TO BANIC CHIROPRACTIC CLINIC

Patient Name: _____ Date: _____

Address: _____ Apt. #: _____

City_____ State:_____ ZIP: _____ eMail: _____

Home Phone: (___)_____ Cell: (___)_____ Work: (___)_____

Best Way to Reach You: Home ☐ Work ☐ Cell ☐ eMail: ☐

Social Security #: _____-____-_____ Date of Birth: _____ Age: _____ M F

Occupation: _____ Employer: _____

Employer Address: _____

Marital Status: Single Married Number of Children: _____ Ages: _____

Spouse's Name: _____ SSN#: _____-____-_____ DOB: _____

Address: _____ Phone: _____

Emergency Contact: _____ **Phone**: _____

Where did you learn about our office & may we contact them?_____

What is your chief complaint today?_____

Have you received Chiropractic Care in the past? Y N When? _____

Please describe the reason for previous care: _____

Name of previous Chiropractor(s): _____

Name of Primary Care Practitioner(s): _____

Name of Insured: _____ Relationship: _____

Primary Health Insurance: _____ Policy #: _____

Primary Health Insurance Phone # (located on back of card): _____

Secondary Health Insurance: _____ Policy #: _____

Secondary Health Insurance Phone # (located on back of card): _____

Is this visit a result of: Personal Injury Auto Accident Workers Compensation

Attorney Name and Phone # (if applicable): _____

WELCOME TO BANIC CHIROPRACTIC CLINIC

Name:_____ #_____ Date:_____

ACTIVITY HISTORY AND SOCIAL HABITS

Most Common Work Activity:
a) Sitting b) Standing c) Lifting d) Overhead Work e) Twisting
Describe areas of difficulty:_____

Would You Consider Your Job Stressful: (No Stress)–1-2–3–4–5–6–7–8–9-10-(Very)

Do You Participate in any Sports Activities or Physical Recreation? No Yes
Describe:_____
Is your Exercise Routine: None Moderate Daily Heavy

Do you Wear: Heel Lift Shoe Lift Arch Support Orthotics Knee/Ankle Brace

Do you Sleep well? No Yes *Describe:* _____
Hours/Night: _____ *Do you Sleep on your?* Back Side Stomach *Snoring*? No Yes
What kind of Pillow do you use? Special Ergonomic Thick Thin Medium None

Habits: Alcohol drinks/week_____ Smoking packs/day_____ Caffeine cups/day_____

Please list all allergies: _____

HEALTH HISTORY

Please circle the following conditions you may have had or have now:

Skin:	Rashes	Itching Skin	Lumps
	Easily Bruise	Dry Skin	Color Changes
Hair:	Abnormal Loss	Abnormal Growth	
Nails:	Brittle	Color Changes	

____ None of the above

Head:	Headaches	Head Injury	Fainting Spells
	Dizziness	Seizures	Fever over last 10-14 days

____ None of the above

Eyes:	Pain	Eye Injury	Infections
	Light Sensitivity	Blurred Vision	Double Vision
	Spots before Eyes	Eye Watering	Redness

____ None of the above

Ears:	Pain	Itching	Excess Wax
	Ringing	Hearing Loss	Loss of Balance
	Discharge	Infections	

____ None of the above

Sinus:	Pain	Dryness	Bleeding
	Congestion	Allergies	Frequent Colds
	Broken Nose	Loss of Smell	Loss of Taste

____ None of the above

Throat:	Pain	Sore / Scratchy Throat	Swollen Glands
	Gagging/Choking	Hoarseness	Difficulty Swallowing
Mouth:	Cavities	Dentures	Mouth Bleeding
Jaw:	Jaw Clicking	Jaw Pain	

____ None of the above

Respiratory System

Lungs:	Chest Pain	Shortness of Breath	Allergy
	Breath Odors	Cough / Phlegm	Fatigue / Lightheadedness
	Sleep Apnea	Chest Noises/Rasping	Asthma

____ None of the above

Cardiovascular System

Heart:	High Blood Pressure	Poor Circulation	Chest Tightness/ Pressure
	Irregular Heart Beat	Pain with Exertion	Racing Heart / Palpitations
	Skin Color Changes	Swollen Ankles/Feet	Calf Pain with Walking
	High Cholesterol	Heart Disease or Stroke History	

____ None of the above

Abdomen:	Pain	Frequent Gas	Unexplained Weight Loss
	Nausea	Vomiting	Yellow Skin/Eyes
	Appetite Problems	Constipation / Diarrhea	Food Allergies

____ None of the above

Genital and Urinary System:

Pain with Urination	Difficult Urination	Change in Frequency
Prostate Problems	Blood in Urine	Recurrent Bladder Infection
Yeast Infections	Itching	Discharges
Menstrual Irregularity	Menstrual Cramping	Spotting between periods
Vaginal Discharges	Difficulty getting Pregnant	Difficulty being Pregnant
Breast Swelling	Breast Lumps	Dimpling /Nipple Retraction

____ None of the above

Nervous System:	Twitching	Numbness	Tingling
	Aches and Pains	Loss of Balance	Coordination Problems
	Nervousness	Convulsions	Memory Lapses
	Depression	Mental Health Problems	

____ None of the above

Other:	Alcoholism	Anemia	Arthritis
	Cancer	Diabetes	Gall Bladder
	Epilepsy	Measles	Blood Vessel Disease
	Ulcers	Multiple Sclerosis	Miscarriage
	Neuritis	Gout	Pneumonia
	Thyroid Problems	Low Blood Sugar	Migraine

____ None of the above

ASSIGNMENT AND RELEASE

I authorize release of my health care information to other healthcare practitioners.
I authorize release of my health care information to insurance companies.
I authorize the taking of photographs and X-rays to be used for diagnostic purposes.
I authorize the performance of other diagnostic and therapeutic procedures.
I authorize my insurance benefits to be paid directly to: Banic Chiropractic Clinic.

Patient's Signature: _____ Date: _____

PAYMENT POLICIES

1. PAYMENT OF YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR FIRST OFFICE VISIT.
2. At the completion of your first office visit, you will be advised to return for a second visit at which time the doctor will provide you with information regarding your examination results and your treatment plans if your case is accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.
3. Although we verify insurance coverage as accurately as possible, the INSURANCE COMPANIES DO NOT GUARANTEE ANY PAYMENTS, therefore you are financially responsible for any denied payments and/or remaining balance. We **STRONGLY** recommend that you call your insurance carrier and very benefit specifics.
4. All massage appointments require 24 hours' notice for cancellation or any schedule changes. There is a 40.00 fee for no-shows or cancellations. Such penalties are not covered by insurance and are your responsibility.

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

HIPPA (HEALTH INSURANCE PORTABLILITY AND PRIVACY ACT)

Drs. Banic and staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If you are not available, a message may be left on your answering machine or with a family member.

We offer spinal adjustments and other therapeutic procedures in an open-adjusting room style, with other patients in the same room. Occasionally comments about your symptoms, improvements, or lack thereof may be discussed during your office visits. You may request a private adjustment at any time with no need for explanation.

We perform online insurance billing services through an insurance clearinghouse. All your healthcare information is protected in this process by HIPAA. We have invested in current virus protection and removable and locking hard drives to further protect your health information.

You have the right to refuse us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization by mailing a request to our clinic at any time. We will not be able to honor your request if your health information has already been released and it may not extend to information required by your insurance company to settle your claims.

I authorize Banic Chiropractic Clinic to use or disclose my health information in the manner described above. I also understand that I may request a copy of this form.

_____ _____

Patient's Signature Date

NOTICE OF PRIVACY PRACTICES

HIPAA, the Health Insurance Portability and Accountability Act of 1996 has recently been formalized and will help govern the relationship between patients and their providers of Health Care to provide all entitled Medical Services in the most efficient way.

THIS PACKET DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION.

Please Read and Review it Carefully

If you have any questions about this notice, please contact our office. We appreciate the trust that patients place in us and we recognize the importance of protecting the confidentiality of non-public personal information that we have in our possession. This information will be used only to ensure accuracy in carrying out treatments for you and in keeping your records. When conducting transactions with patient designated health carriers or affiliates, we will always endeavor to use information that is absolutely necessary to comply. If we change this policy, we will notify you in advance.

This notice describes the information privacy practices that are followed by our employees, physicians and all other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status and the healthcare/services you receive at this office. It also reviews the ways in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity or your care. We are required by law to give you this notice and to help you understand its intent. You must signify your understanding and agreement by signing and dating this cover sheet for our records. You may opt out of this agreement at any time by presenting this office with written notice of your wishes.

Patient or Guardian Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Massage Cancellation Policy

Massage times are reserved specifically for you. Because of this we require your credit card on file to hold your appointment. Any changes or cancellation of your appointment requires a 24 hour notice to us by phone or email. There is a $40 fee for no-shows or cancellations and a $15 fee for late arrival (14 minutes or more). Such penalties are not covered by insurance and are your responsibility and will be charged to the credit card on file.

Patient Signature: _____ Date: _____