WELCOME TO

EAST VILLAGE CHIROPRACTIC

start here

Our goal is to provide you with the best and most appropriate care for your health issues. First, we will go through a process of diagnosing your problem, to identify what is actually causing your pain. Second, we will determine the best course of action for your care. Often times, we can provide you with the relief you need. However, if your problems are beyond our abilities, we will quickly refer you to another health care provider for help. One way or the other, we are determined to get you back on your feet and feeling the best you can!

We value, above all else, a person's sense of self. Any questions or concerns you may have prior to care being provided will be answered to the upmost of our knowledge. We look for your feedback, and will modify your care plan to fit your needs.

For our patient with insurance, we will file your claims for you and help guide you through the arduous paperwork process. As the patient, you will need to pay any deductible, coinsurance, or copay as indicated by your insured benefits. These payments will be expected at the time of service. We do understand challenges present themselves financially, so please talk with our office manager if you have any concerns.

We do offer a "fee at time of service" option. This is a reduction in fees if we are not required to file insurance claims and all that is involved there. We accept cash, credit card, or checks.

For Medicare patients, examinations are non-covered benefits. Therefore, the patient must pay for these services. Since we do participate with Medicare, your costs are limited to Medicare's allowable charge.

We have a very flexible scheduling policy. Therefore, we have a process in place to help maintain a proper course of care for people. You will receive a reminder the day before your appointment. If you are not able to make your appointment, a call or text would be greatly appreciated. We will try to quickly reschedule your appointment for convenience and consistency.

Thank you for visiting us at East Village Chiropractic. Let us know if we can do anything to make your experience better. If you are happy with your service, the best 'thank you' we can receive are referrals of your friends and family.

We are glad you are here and will provide the highest quality of care we can.

Patient Name: _____

Signature: _____

Date: _____

Start Here for better health!

EAST VILLAGE CHIROPRACTIC start here

CONFIDENTIAL PATIENT DEMOGRAPHICS

First Name:		Last Name:
Street Address:		
City:	State:	Zipcode:
Home Phone:		Cell Phone:
Email Address:		
Social Security Number:	Sex:	Birthdate:
Medical Doctor:		MD's Location:
Marital Status:		Spouse's Name:
How did you hear about us?		

Insurance Carrier Information for filing purposes:

Who is your insurance carried under?		
Their first name:		Their Last name
Their Date of Birth		
Street Address if different from above:		
City:	State:	Zipcode:

Would you be interested in receiving an occasional newsletter or announcement from us via email?

( ) Yes ( ) No

Patient Name:

Patient/Parent/Guardian Signature:

Date:

Doctor Signature:

Start Here for better health!

EAST VILLAGE CHIROPRACTIC start here

CHIROPRACTIC CASE HISTORY

What is your main complaint?
Location of complaint
When and how did it begin?
Please circle the type of pain: dull aching sharp shooting burning throbbing deep nagging
Does this problem radiate or travel (Shoot) to any part of your body? Yes No
If yes, Where?
Is there any numbness or tingling present in your body? Yes No
If yes, where?
Grade the pain (no pain at all) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
How frequent is the problem? How long does it last?
Does anything make it worse?
Does anything make it better?
Have you tried other treatments such as medications or surgery?
Past Patient History
Who is your medical doctor?
Please list any previous injuries, illnesses or accidents that may have contributed to this problem.

Date and Type of any surgical procedures	Current Medications (use bottom of page if necessary)
Pregnancies/Outcome/Delivery Date	Family history of musculoskeletal injury

Social and Occupational History
Level of Education: __ High School __ some College __College Graduate __ post Graduate studies
Occupation:
Brief summary of work environment:
Recreational / exercise activities
Smoker / non smoker ____ number of alcoholic drinks per week Recreational drug use? Y N
Patient Name:
Patient/Guardian/Parent Signature
Date:
Doctor signature:

EAST VILLAGE CHIROPRACTIC start here

CONFIDENTIAL PATIENT HEALTH SURVEY

Patient Name:_____ Date:_____

Dr. Signature:_____

O – I occasional have this problem, maybe a few times a year

F – I frequently have this problem, several times a month or more

O	F	General
		Allergies
		Chills
		Convulsions
		Dizziness
		Fainting
		Fatigue
		Fever
		Headache
		Loss of Sleep
		Loss of Weight
		Nervousness
		Depression
		Sweats
		Tremors

O	F	Muscle and Joint
		Arthritis
		Bursitis
		Fibromyalgia
		Foot trouble
		Hernia
		Low back pain
		Neck pain
		Shoulder issues
		Arm issues
		Elbow issues
		Hand issues
		Hip issues
		Leg issues
		Knee issues
		Painful tailbone
		Poor posture
		Sciatica
		Spinal curvature
		Swollen joints

O	F	Gastro-intestinal
		Belching / Gas
		Colitis
		Colon issues
		Constipation
		Diarrhea
		Digestion trouble
		Excessive Hunger
		Gall Bladder issues
		Hemorrhoids
		Jaundice
		Liver problems
		Nausea
		Pain over stomach
		Low appetite
		Vomiting

O	F	Eyes, Ears, Nose, Throat
		Asthma
		Colds
		Crossed eyes
		Deafness
		Earache
		Ear discharge
		Ear noise
		Enlarged thyroid
		Eye pain
		Failing vision
		Gum trouble
		Hoarseness
		Nasal obstruction
		Nose bleeds
		Sinus infections
		Sore throat
		Tonsillitis

O	F	For Women Only
		Menopausal symptoms
		Painful Periods
		Vaginal Discharge

O	F	Cardio-vascular
		Hardening of arteries
		High blood pressure
		Low blood pressure
		Chest pain
		Poor circulation
		Rapid heart beat
		Slow heart beat
		Swollen ankles

O	F	Respiratory
		Chest Pain
		Chronic Cough
		Trouble breathing
		Spitting up blood
		Spitting up phlegm
		wheezing

O	F	Skin
		Boils
		Bruising
		Dryness
		Hives
		Itching
		Rashes
		Varicose veins

O	F	Genito-Urinary
		Bed wetting
		Blood in urine
		Frequent urination
		Bladder control issues
		Kidney issues
		Painful urination
		Prostate issues
		Pus in urine

O	F	
		Cramps or back ache
		Excessive flow
		Irregular Cycles

INSURANCE STATEMENT

Your insurance provider will only pay for services that they determine to be medically necessary. As a patient, you should understand that some or all of the services provided to you might not be covered by your insurance carrier. It varies from carrier to carrier and we do our best to meet their internal requirements. You, as the patient, are liable for all charges your plan doesn't cover. We strive to stay on top of this, and make it our goal to avoid any surprises for you the client.

I have been notified by my physician that my insurance may not cover all the services provided to me for my care. If payment is denied for these services, I agree to be fully responsible for payment.

Printed Name:_____

Signature:_____

Date:_____

Start Here for better health!

EAST VILLAGE CHIROPRACTIC
start here

PRIVACY STATEMENT

This practice is committed to maintaining the privacy of your Protected Health Information (PHI). This includes information about your health condition, appointments at the office, and any care you receive at East Village Chiropractic. This notice details how this information may be used in this office.

With Consent from you, it is the policy of this office to use your PHI in the following manners:

1. Treatment: Your PHI will be given to those professionals that require it to provide you with care
2. Appointment reminders: Our staff will either call or text the number you have provided to remind you of appointments
3. Sign in Log: We maintain a log of incoming patients for our own use
4. Referral Programs: We like to thank those that support us and look for ways to show appreciation.
5. Medical Doctors: We like to have permission to share our findings with your medical doctor to foster better care and communication for your benefit.

In these special circumstances, your PHI may be disclosed:

1. Personal representative, in accordance with applicable law that may represent you.
2. Emergency situations
3. Abuse, neglect, or domestic violence
4. Law enforcement issues
5. Worker's Compensation claims
6. Avert a potential health threat

Your rights regarding your health information

1. Right to inspect and obtain a copy of your records
2. Amend your PHI by submitting a written request with explicit reasons
3. Request restrictions to your PHI; we are not obligated to agree to any such restrictions
4. Revoke consent at any time
5. Complain to the practice

Printed Name:_____

Signature:_____

Date:_____

Start Here for better health!