Back To Health Chiropractic
120 Tompkins St.
Cortland, N.Y. 13045
Tel: (607) 753-1884 Fax: (607) 753-1540

Patient Name: _____ D.O.B. _____ M/F
(circle) Single/Married/Divorced/Separated/Widowed/Other

HOME
Address: _____ City: _____ State: _____ Zip: _____

Student - College Address_____

Tel# (___)_____Cell Phone: (___)_____Social Security#: _____

Email address: _____

Occupation: _____ Employer: _____ Phone#: (___) _____

Address:_____ City: _____ State: _____ Zip: _____

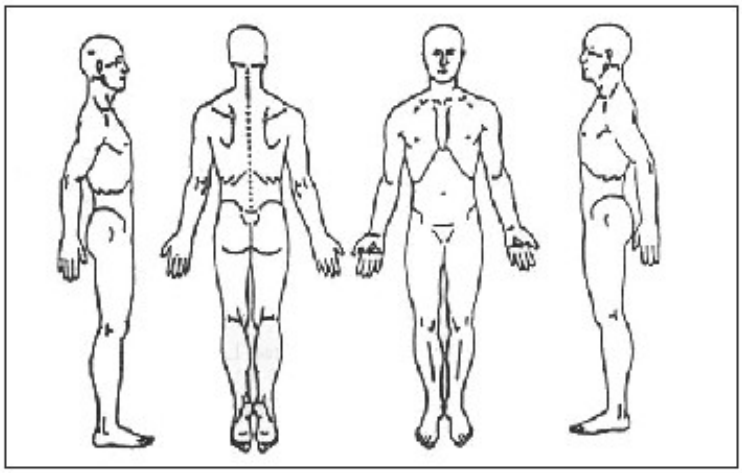
Spouse Name: _____Spouse Employer: _____City: _____ State: _____Zip:_____

Primary Health Plan:_____ Subscriber Name:_____DOB:_____
ID: _____ Group #: _____

Secondary Health Plan:_____ Subscriber Name:_____ DOB:_____
ID: _____ Group #: _____

Primary Care Physician Name: _____ PCP Phone: (___)_____
Who referred you here _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
( ) Headache ( ) Neck pain ( ) Mid back pain ( ) Low back pain ( ) Arm/Hand ( ) Leg/Foot

( ) Other _____

Is This? ( ) Work Related ( ) Auto Related ( ) N/A

Date Problem Began: _____How Problem Began:_____

Current Complaint (how you feel today) 0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable pain

How often are your symptoms present?
Intermittent ( ) 0 – 25% ( ) 26 -50% ( ) 51 – 75% ( ) 76 -100% (Constant)

CONTINUED ON BACK

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? YES/NO

Dates Taken: _____ What areas were taken? _____

Facility where taken: ( ) Cortland Regional Medical Center ( ) Cayuga Medical Center ( ) other _____

Please check all the following that apply to you: Height_____ Weight_____

( ) Numbness in arms/hands legs/feet
( ) Recent Fever
( ) Diabetes
( ) High Blood Pressure
( ) Stroke (date)_____
( ) Corticosteroid use (cortisone, prednisone, etc.)
( ) Taking Birth Control
( ) Dizziness/Fainting
( ) Thyroid condition
( ) Cancer/Tumor (explain) _____
( ) Alcohol
( ) Osteoporosis
( ) Epilepsy/Seizures
( ) Other Health Problems (explain)_____
_____

( ) Blood Thinners
( ) Prostate Problems
( ) Menstrual Problems
( ) Urinary Problems
( ) Pregnant? Due date____ births __ vag/C-section
( ) Abnormal Weight ( ) gain ( ) Loss
( ) Marked Morning Pain/Stiffness
( ) Pain Unrelieved by position/rest
( ) Pain at Night
( ) Visual Disturbances
( ) Smoke/packs per day _____ # years_____
( ) Surgeries _____
_____
_____
( ) Medications: _____
_____

Family History (Siblings & Parents)
( ) Cancer ( ) Diabetes ( ) High Blood Pressure ( ) Heart Problems/Stroke ( ) Rheumatoid Arthritis

OFFICE POLICY

Payment: I am aware that my deductible and co-payment of fees for services are my responsibility and must be paid on the day the service is received. I must provide the necessary information and materials required by my insurance to enable Back to Health Chiropractic to submit my claim to my insurance company(s) to receive payment for covered services. If your account is sent to collection for non payment, you will be responsible all and any collection fee.

Referrals: Some insurance companies require a referral from the primary care physician prior to treatment. If the referral is not obtained, the insurance company will deny coverage. All fees will be the patient's responsibility.

Cancellations: If you are unable to keep a scheduled appointment, please notify us at least 2 hours before your scheduled time. Failure to give notice will result in a $25 charge for the missed appointment.

Returned Check Fee: There is a $20 handling fee on returned checks.

Please be advised:
All fees may be your responsibility if your insurance company does not approve coverage of services provided.

I certify to the best of my knowledge, I have read and understand the information on this form. My answers are complete and accurate.

I hereby instruct and direct the above named Insurance Company to pay by check made out and mailed directly to BACK TO HEALTH CHIROPRACTIC, for the payable amount of the professional or medical expense benefits allowable, and otherwise payable to me under my current Insurance policy as payment toward the total charges for professional services rendered. I also authorize the release of any information pertinent to my case to any insurance company, doctor, adjuster, or attorney involved in this case.

A photocopy of this Assignment shall be considered as effective and valid as the original.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

_____ _____

Patient's Signature Date 2-17-20