

Triad Upper Cervical Clinic

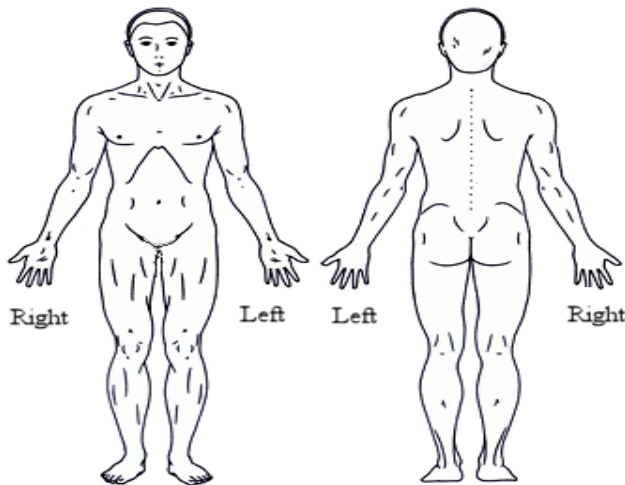
Confidential Patient History

Name _____ Date _____
 Address _____ State _____ Zip _____
 H. Phone (_____) _____ W. Phone _____
 Email address _____ Date of Birth _____
 Occupation _____ Employer _____
 Marital Status S M D W Spouse Name _____
 Spouse's Occupation _____ Number of children/Ages _____
 Have you ever received Upper Cervical Care? Yes No Referred by _____
 Insurance _____

Give a brief detailed description of the problem you are currently experiencing: _____

How long have you had this condition? _____ Is it getting worse? yes, no
 Does it bother you (check appropriate box): work sleep other: _____
 What seemed to be the initial cause: _____

Please indicate areas of pain, if applicable:



Habits	None	Light	Mod.	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sodas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Past health history

Have you... Yes No If yes, explain briefly
 ... been hospitalized in the last 5 year? _____
 ... had any mental disorders? _____
 ... had any broken bones? _____
 ... had any strains or sprains? _____
 ... ever used orthotics? _____
 Do you take minerals or vitamins? _____
 How is most of your day spent? standing, sitting, other: _____
 In what position do you sleep? (circle) back side stomach

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease | | |

Triad Upper Cervical Clinic

Put a check by any of the following conditions that you have or have had:

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Mental illness <input type="checkbox"/> Nervousness <input type="checkbox"/> Tremors <input type="checkbox"/> Weight loss / gain <p>Muscle / Joint</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis / rheumatism <input type="checkbox"/> Bursitis <input type="checkbox"/> Foot trouble <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Low back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Joint pain <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Boils <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Hives or allergies <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Varicose veins <p>Eye, Ear, Nose & Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Colds <input type="checkbox"/> Deafness <input type="checkbox"/> Ear ache <input type="checkbox"/> Eye pain <input type="checkbox"/> Gum trouble <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Ringing of the ears <input type="checkbox"/> Sinus infection <input type="checkbox"/> Sore throat <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Vision problems 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloody or tarry stool <input type="checkbox"/> Colitis / Crohn's <input type="checkbox"/> Colon trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficult digestion <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Bloating abdomen <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Gallbladder trouble <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Intestinal worms <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver trouble <input type="checkbox"/> Nausea <input type="checkbox"/> Painful defecation <input type="checkbox"/> Pain over stomach <input type="checkbox"/> Poor appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting of blood <p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Bladder infection <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney infection <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Pus in urine <input type="checkbox"/> Stress incontinence <p>Urination</p> <ul style="list-style-type: none"> <input type="checkbox"/> Overnight more than twice <input type="checkbox"/> More than 8x in 24hrs <input type="checkbox"/> Decreased flow/force <input type="checkbox"/> Painful urination <input type="checkbox"/> Urgency to urinate <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Hardening of the arteries <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Pain over heart <input type="checkbox"/> Palpitation <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Slow heart beat <input type="checkbox"/> Swelling of ankles 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Chronic cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Hay fever <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Spitting up phlegm / blood <input type="checkbox"/> Wheezing <p>Women only</p> <ul style="list-style-type: none"> <input type="checkbox"/> Congested breasts <input type="checkbox"/> Hot flashes <input type="checkbox"/> Lumps in breast <input type="checkbox"/> Menopause <input type="checkbox"/> Vaginal discharge <p>Menstrual flow</p> <p><input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain / cramps</p> <p>Days of flow: _____ Length of cycle: _____ Date - 1st day last period: _____</p> <p>Are you pregnant? <input type="checkbox"/> yes, <input type="checkbox"/> no If yes, how many months? _____</p> <p>How many children do you have? _____</p> <p>Birth control method: _____</p> <p>Date of last PAP test: _____ <input type="checkbox"/> normal, <input type="checkbox"/> abnormal</p> <p>Date of last mammogram: _____ <input type="checkbox"/> normal, <input type="checkbox"/> abnormal</p>	<p>Check any of the conditions you have or have had:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Chicken pox <input type="checkbox"/> Cold sores <input type="checkbox"/> Diabetes <input type="checkbox"/> Eczema <input type="checkbox"/> Edema <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart burn <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Influenza <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Miscarriage <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Pace maker <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers
<p>Please list any medication you are currently taking and why:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			

Triad Upper Cervical Clinic

FINANCIAL OFFICE POLICY

- 1) A detailed description for the services to be rendered by M. Chad McIntyre, D.C., P.C. (hereby referred to as “clinic”) after the initial consultation, examination, and report of findings are determined by clinical data following the first upper cervical correction and subsequent follow-up.
- 2) Dr. McIntyre will determine a care plan for you based on the above and arrange a payment plan for you (and/or your family) to try and fit your budget. The clinic fully understands the healthcare costs these days and wants to ensure that money does not take precedent over that which is most important: the health of you and your family.
- 3) The clinic does not participate with many insurance carriers. It is likely that the majority, if not all of the services rendered by the clinic may not be covered by your carrier. However, provided you allow the clinic a copy of your insurance information on your first visit, your coverage will be verified.
- 4) After coverage and deductible information proves adequate, the clinic may accept assignment of benefits on most policies provided you sign an appropriate assignment of benefits form authorizing payments be sent to the doctor. You would then be responsible for co-payments and any non-covered visits.
- 5) Advanced Beneficiary Notice of Non-Coverage (ABN): Medicare typically does not pay for the following services – Cervical X-rays (72050), Comprehensive Patient Examination (99203), or Evaluation and Management of your Upper Cervical spinal condition (99212/99213). These are the main services rendered by the clinic.
- 6) Insurance policies are an arrangement between an insurance carrier and you, the insured. So, the clinic cannot guarantee that an insurance company will pay. Any services that the insurance company does not pay for will be **your** responsibility.
- 7) Accepting insurance assignment is more a courtesy for **your** benefit. In the event that a dispute with your insurance company arises, the clinic expects that you will directly assist in the matter.
- 8) If you receive any correspondence or checks from your insurance company, you agree to bring them into the clinic so that we may mutually determine if any action needs to be taken or if the check is an assignment to the clinic.
- 9) If you are referred to another specialist or discontinue care for any reason other than discharge from the doctor, then you will be expected to pay your remaining balance. Prepaid services are non-refundable in these circumstances.
- 10) If you change insurance companies or employers, you agree to provide the clinic with your updated information for our records and so that we may better assist you.
- 11) The clinic accepts cash, checks, MasterCard and Visa.
- 12) If you have any questions concerning this or any other financial matter, please just ask...

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient signature

Date

Triad Upper Cervical Clinic

Authorization to pay Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

Signature

Date

Authorization to pay/release is granted to:

M. Chad McIntyre, D.C., P.C.
432A W. Mountain St.
Kernersville, NC 27284

Triad Upper Cervical Clinic

PATIENT CONSENT FORM

With my consent, M. Chad McIntyre, D.C., P.C. (hereby referred to as “clinic”) may use and disclose protected health information to carry out treatment, payment, and healthcare options. The clinic may call my home or other designated location and leave a voicemail message (if patient is not available) in reference to any item that may assist in such matters as reminders of appointments and discussions of insurance or items pertaining to my upper cervical chiropractic case. The clinic may also mail to my home or other designated area such items as patient statements.

By signing below, I am consenting to the clinic’s use and disclosure of my protected health information to carry out treatment, payment, and healthcare options.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. By signing below, I am giving my informed consent to be given upper cervical chiropractic care, provided that the clinic determines that I am a viable candidate.

Signature of Patient or Legal Guardian