Personal Information

Name ____ Date of Birth ____/____/________ Age ________

Address ____ City ______________________ Zip Code ________

Home Phone _(_________)_________-_____________ Cell Phone _(_________)_________-_____________

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed Gender Male Female Other

Race______________ Ethnicity______________ Language_______________ Gender Identity______________

Primary Care Physician ________________________________ Email Address _____________________________

Occupation ____ Employer ___________________________________

Employer Address ____

Employer Phone # _(_________)_________-_____________

Non Insured/Self Pay

Primary Insurance Company

Insurance Company ____

Policy Holder ____ Date of Birth ____/____/________

Insurance Address ____

Insurance ID/Policy # ____ Group # ____________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _________________________

Secondary Insurance

Insurance Company ____

Policy Holder ____ Date of Birth ____/____/________

Insurance Address ____

Insurance ID/Policy # ____ Group # ____________________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _________________________

Emergency Contact _______________________ **Phone** _(_______)________-_________ **Relation** ________

Reason for Visit ____

Referring Provider ____

Signature of Patient ____ **Date** _____/_____/_________

General Health Information

AIDS
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Bleeding Disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Drug Addiction
Chicken Pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Gout
Heart Disease
Hepatitis
Hernia
Herpes
High Cholesterol
HIV
Kidney Disease
Liver Disease
Measles
Migraines
Mononucleosis
Multiple Sclerosis
Pacemaker
Pneumonia
Prostate Issues
Psychiatric Care
Rheumatic Fever
Stroke
Suicide Attempt
Thyroid Issues
Tonsilitis

General

Chills
Dizziness
Fainting
Forgetfulness
Heaviness Sensation
Unusual Sensation
Loss of Weight
Numbness Sensation
Cold Hands and Feet
Hair Loss
Unusual Swelling
Restlessness
Night Sweats
Fatigue
Mental Sluggishness

Muscle, Joint, and Bone

Head
Neck
Arms
Hands
Back
Hips
Legs
Feet
Knees
Jaw
Flank/Rib Pain
Shoulders

Ear, Nose, and Throat

Bleeding Gums
Blurred Vision
Floaters in Eyes
Watery Eyes
Crossed Eyes
Earache
Ear Discharge
Ringing in the Ears
Loss of Hearing
Sinus Issues
Nose Bleeds
Vision Problems

Digestive System

Nausea
Vomiting
Poor Diet
Bloating
Diarrhea
Constipation
Abdominal Pain
Diverticulitis
Gas
Hemorrhoids
Frequent Weight Change
Excessive Appetite
Indigestion
Ulcers
Loose Stools
Excessive Thirst
Irritable Bowel Syndrome
Blood in Stool
Undigested Food in Stool
Frequent Belching
Frequent Hiccups
Bad Breath
Mouth Sores

Skin, Hair, and Nails

Dry Skin
Hives
Itching
Rash
Scars
Sores that won't heal
Hair Loss
Brittle Nails
Loss of Pigment

Genito-Urinary

Blood in Urine
Frequent Urination
Frequent UTI's
Painful Urination
Kidney Stones
STD

Name ____ Date _____/_____/_________

Cardiovascular and Pulmonary
Chest Pain
High Blood Pressure
Irregular Heartbeat
Poor Circulation
Rapid Heartbeat
Ankle Swelling
Varicose Veins
Shortness of Breath
Palpitations

Mental Health
Depression
Nervousness
Irritability
Irritated Easily
Over Thinking
Worrying
Anxiety
Difficulty Making Decisions
Mental Confusion
Easily Angered
Easily Startled
Frustration

Please list any previous surgeries:

1. ____ Year ____________
2. ____ Year ____________
3. ____ Year ____________
4. ____ Year ____________
5. ____ Year ____________

Please list any family history:

1. ____
2. ____
3. ____
4. ____
5. ____

Medication List: Name/Dosage/Per day

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Name ______________________________________ Date _____/_____/_________

Patient Name: ____ Date of Birth: ________________

What other health issues can we help you support?

☐ Hormonal Balance ☐ Weight Loss ☐ Stress Management ☐ Gut Health ☐ Anti-Aging

☐ Thyroid Health ☐ Detoxification ☐ Insulin Resistance ☐ Sleep ☐ Inflammation

☐ Other: ____

Health History (please check all that apply):

☐ Heart Attack / Stroke ☐ Irritable Bowel Syndrome ☐ Rheumatoid Arthritis

☐ High Blood Pressure ☐ Crohn's Disease ☐ Multiple Sclerosis

☐ Low Blood Pressure ☐ GERD ☐ Celiac Disease

☐ High Cholesterol ☐ Gallbladder disease ☐ Hashimoto's Hypothyroid

☐ Circulatory Disorder ☐ Gallbladder removed ☐ Psoriasis

☐ Hemochromatosis ☐ Liver disease ☐ Eczema

☐ Diabetes ☐ Hepatitis ☐ Epstein Barr Virus

☐ Cancer ☐ Hyperthyroid ☐ Fibromyalgia

☐ Bariatric/Weight loss surgery ☐ Hypothyroid ☐ Musculoskeletal pain

Other: ____

Medications & Supplements (please list ALL medications & supplements you are currently taking):

Medication / Supplement	Reason	How long?

____

Patient Signature Date

Balance Chiropractic & Wellness Center, LLC
P: 732-903-2222 F: 732-903-2111

Assignment of Benefits Form

Patient: ___________________________ SS#: _____-____-_______ DOB: ____/____/________

Claim #: __________________________________ Policy #: ____________________________________

I hereby instruct and direct ____
Insurance Company to pay by check made out and mailed to:

Balance Chiropractic & Wellness Center, LLC
1999 Route 88, Brick, NJ 08724

Or, if my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: **Balance Chiropractic & Wellness Center, LLC, 1999 Route 88, Brick, NJ 08724** for the professional or medical expensebenefits allowable and otherwise payable to me under my current insurance policy as payment toward the totalcharges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS ANDBENEFITS UNDER THIS POLICY. This serves as my written authorization for assigning all my rights andbenefits payable under my insurance coverage **for** Chiropractic and/or Acupuncture and/or physical therapyservices rendered to me, by this provider in connection to any insurance policy and/or claim otherwise payableto me. This assignment is irrevocable. I request that you respond to **Balance Chiropractic & WellnessCenter, LLC** with a written communication, confirming the approval of my authorization. If they do not receive a written confirmation from you within ten (10) days, I will deem that my request has been authorized by you. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment that is not prohibited by law.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to my health insurance and/or the Insurance Commissioner or any other government agency for any reason on my behalf.

Signature of Policy Holder ____ Date _____/_____/_________

Balance Chiropractic & Wellness Center, LLC
P: 732-903-2222   F: 732-903-2111

CONSENT FOR DISCLOSURE OF PATIENT INFORMATION

The Privacy Rule that is contained in HIPPA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations. The following information must be included in a patient record release form used by the Practice to be in compliance with HIPPA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. I have the right to review the provider's notice of privacy practices before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practices. Changes in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment, or health care operations purposes. I understand that the provider may not be able to comply with this request. I request the following special restriction(s):

Anyone we are allowed to converse with about your health information excluding doctors:

Name ____

I understand that from time to time my physician and his/her staff may inform me of new treatments, or other services, that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.). I consent to the use of my identifiable patient information to notify me of such new treatments, or other services, that may be necessary for the continuity of my care or which may be of benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund raising, or similar purposes without my specific consent.

I understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my patient record. I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this content.

Patient Name: ____

Signature: ____ Date _____/_____/_________

<u>Cancellation/No Show Policy for New Patient Appointments</u>

We understand that there are times when you miss an appointment due to emergencies and obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, we are unable to schedule you for a visit, due to seemingly “full” appointment book.

Patients who do not show up for their new patient appointment without a call to cancel the appointment within 24 hours will be considered a no show. You will be charged a fifty-dollar fee ($50) with the credit card number you have provided to us. This will not be covered by insurance.

Please sign that you have read and understand the agreement to the Cancellation and No-Show Policy for New Patient Appointments.

Patient Name: ____ DOB: ________________

Signature: ____ Date: _________________