Chiropractic Health Center of Hamburg

PatientHealth Questionaire

Name_____ Social Security#_____ Date_____

Street_____ City_____ State_____ Zip_____

PO Box_____ City_____ State_____ Zip_____

Birthdate___/___/_____ Age_____ Home phone #_____ Business _____

Cell phone #_____ Drivers License #_____

Single ( ) Married ( ) Divorced ( ) Separated ( ) Pregnant ( ) Male ( ) Female ( )

E-mail address_____

Present Complaints/Symptoms

Description of your condition_____

Date of onset_____ How did it start_____

How often are your symptoms present

( ) Constant (76-100% of day) ( ) Frequent (51-75% of day) ( ) Occasional (26-50% of day) ( ) Intermittent (0-25% of day)

Describe your symptoms

( ) Sharp ( ) Dull Ache ( ) Numb ( ) Tingling ( ) Burning ( ) Other_____

What makes it worse

( ) Sitting ( ) Standing ( ) Bending ( ) Twisting ( ) Walking ( ) Lifting ( ) Coughing/Sneezing ( ) Other_____

What makes it better

( ) Ice ( ) Heat ( ) Stretching ( ) Walking ( ) Sitting ( ) Laying on side/ stomach/ back ( ) Other_____

Pain Scale

None< 1 2 3 4 5 6 7 8 9 10 >Unbearable

Past Health History

( ) Asthma	( ) Allergies	( ) Arthritis	( ) Broken Bones	( ) Gout	( ) Emphysema
( ) Cancer	( ) Colitis	( ) Constipation	( ) Diabetes	( ) Leg Pain	( ) Flat feet
( ) Neck Pain	( ) Hernia	( ) Herniated Disc	( ) Sciatica	( ) Heartburn	( ) Headaches
( ) Scoliosis	( ) Low Back Pain	( ) Carpal Tunnel	( ) Chronic Ear Ache	( ) Other_____	

Type Of Payment: ( ) Insurance ( ) Worker's Comp. ( ) Auto Accident ( ) Medicare ( ) Cash

Person's Name on Policy:_____ SS#_____ Birthdate_____

How did you hear about our Office? A Friend? Please list their name _____

( ) PhoneBook ( ) Insurance Book ( ) Val-Pak Coupon ( ) Radio Advertisment

Who can we contact in case of Emergency: Name _____

Address:_____ Phone Numbers:_____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of benefits to Dr. Peter B. Karas for services rendered. I understand that I am financially responsible for and hereby guarantee payment for all services rendered. Although fees for services are due and payment expected at the time services are rendered, If I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

IF YOU ARE A MEDICARE RECIPIENT:

I request payment under the Medicare Program to be made directly to Dr. Peter B. Karas on my behalf. I agree to pay any balance due which Medicare does not or will not pay. Including but not limited to co-insurance, annual deductible, services not covered or rejected for any reason. I understand the total amount due is my responsibility until the total amount due is satisfied..

IF YOU ARE COVERED BY INSURANCE:

I request all payments be made to Dr. Peter B. Karas directly for covered services. I agree to pay any amount the ins. co. did not or will not pay.

I also agree to pay all collection fees, court costs, attorney fees and interest fees accrued with the collection of this account.

_____ _____

Responsible Party **Date** **Patient Signature** **Date**