



1400 16th AVE SW GREAT FALLS, MT
Ph: (406)-590-5900 Fax: (406) 453-5197
Email: cranechiro@bresnan.net

NEW PATIENT HEALTH HISTORY FORM

NAME LAST FIRST MI DATE EMAIL USED FOR OFFICE ANNOUNCEMENTS

ADDRESS CITY STATE ZIP

HOME PHONE # CELL PHONE # WORK PHONE #

SOCIAL SECURITY # BIRTH DATE AGE SEX: M F MARITAL STATUS: S M D W

OF CHILDREN OCCUPATION EMPLOYER HOW LONG

SPOUSE'S NAME DOB SOCIAL SECURITY #

SPOUSE'S OCCUPATION EMPLOYER WORK #

EMERGENCY CONTACT PHONE #

FILL OUT IF PATIENT IS A MINOR

FATHER/GUARDIAN NAME DOB SS#

EMPLOYER PHONE ADDRESS

MOTHER/GUARDIAN NAME DOB SS#

EMPLOYER PHONE ADDRESS

HOW DID YOU HEAR ABOUT US? OFFICE SIGN PHONEBOOK PATIENT: OTHER:

FAMILY PHYSICIAN: PHONE # PAST CHIROPRACTIC CARE?: N Y

WHEN MONTH/YEAR CHIROPRACTOR'S NAME RESULTS: POOR FAIR GOOD

MAIN COMPLAINTS: 1. HOW LONG: PREVIOUS EPISODES: Y N
2. HOW LONG: PREVIOUS EPISODES: Y N
3. HOW LONG: PREVIOUS EPISODES: Y N

ARE YOUR PRESENT PROBLEMS DUE TO AN INJURY: N Y ON THE JOB AUTO ACCIDENT
PERSONAL INJURY OTHER:

OFFICE USE ONLY

HEALTH HISTORY

DO YOU HAVE A PAST HISTORY OF ANY SERIOUS ILLNESSES OR INJURIES?: N Y

EXPLAIN: _____

ARE YOU NOW OR HAVE YOU EVER BEEN DISABLED? (SERVICE OR WORK): N Y WHEN: _____

CHECK ANY CURRENT SYMPTOMS:

- | | | | |
|---|------------------------------------|--|--|
| <input type="radio"/> FEVER | <input type="radio"/> BACK PAIN | <input type="radio"/> COLD SWEATS | <input type="radio"/> LOSS OF MEMORY |
| <input type="radio"/> FATIGUE | <input type="radio"/> FEET COLD | <input type="radio"/> FACE FLUSHED | <input type="radio"/> STOMACH UPSET |
| <input type="radio"/> TENSION | <input type="radio"/> HEADACHE | <input type="radio"/> NERVOUSNESS | <input type="radio"/> NUMBNESS IN TOES |
| <input type="radio"/> FAINTING | <input type="radio"/> NECK STIFF | <input type="radio"/> LOSS OF TASTE | <input type="radio"/> HANDS SEEM HEAVY |
| <input type="radio"/> DIZZINESS | <input type="radio"/> CHEST PAIN | <input type="radio"/> CONSTIPATION | <input type="radio"/> HEAD SEEMS HEAVY |
| <input type="radio"/> DIARRHEA | <input type="radio"/> DEPRESSION | <input type="radio"/> LOSS OF SMELL | <input type="radio"/> SLEEPING PROBLEMS |
| <input type="radio"/> EARS RING | <input type="radio"/> HANDS COLD | <input type="radio"/> BUZZING IN EARS | <input type="radio"/> LIGHTS BOTHER EYES |
| <input type="radio"/> NECK PAIN | <input type="radio"/> IRRITABILITY | <input type="radio"/> LOSS OF BALANCE | <input type="radio"/> NUMBNESS IN FINGERS |
| <input type="radio"/> SHORTNESS OF BREATH | | <input type="radio"/> PINS & NEEDLES IN LEGS | <input type="radio"/> PINS & NEEDLES IN ARMS |
| <input type="radio"/> OTHER _____ | | <input type="radio"/> OTHER _____ | <input type="radio"/> OTHER _____ |

HOW DID THESE SYMPTOMS OCCUR?: _____

DO YOU HAVE ANY MEDICATION ALLERGIES OR OTHER ALLERGIES?: N Y LIST: _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? N Y LIST: _____

DO YOU HAVE ANY BODILY IMPLANTS?: N Y LIST: _____
(PACE MAKER, BREASTS, JOINTS, SCREWS, PLATS, ETC)

HAVE YOU EVER HAD X-RAYS TAKEN?: N Y WHEN?: _____ BY WHOM?: _____

DO YOU SUFFER FROM ANY CONDITION OTHER THAN THAT WHICH YOU ARE NOW CONSULTING US?: N Y
LIST: _____

HAVE YOU HAD ANY SURGERIES?: N Y LIST: _____

WOMEN: ARE YOU PREGNANT?: N Y DATE OF LAST MENSTRUAL CYCLE: _____

EXERCISE: NONE MODERATE DAILY TYPE: _____

HABITS: SMOKING N Y ALCOHOL N Y CAFFEINE N Y SUBSTANCE ABUSE N Y

FAMILY HISTORY:

	DIABETES	HEART/HBP	KIDNEY	CANCER	BACK/NECK	PINCHED NERVE	DISC/JOINT	ARTHRITIS	HEADACHES
MOTHER:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FATHER:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BROTHER(S):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SISTER(S):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?: CHECK ANY THAT APPLY

- | | | |
|--|---|---|
| <input type="radio"/> 011 TUBERCULOSIS | <input type="radio"/> 239 CANCER | <input type="radio"/> 429.9 HEART DISEASE |
| <input type="radio"/> 033 WHOOPING COUGH | <input type="radio"/> 240 GOITER | <input type="radio"/> 480 PNEUMONIA |
| <input type="radio"/> 044 HIV POSITIVE | <input type="radio"/> 250 DIABETES | <input type="radio"/> 487 INFLUENZA |
| <input type="radio"/> 045 POLIO | <input type="radio"/> 280 ANEMIA | <input type="radio"/> 511 PLEURISY |
| <input type="radio"/> 052 CHICKEN POX | <input type="radio"/> 305.0 ALCOHOLISM | <input type="radio"/> 541 APPEDDICITIS |
| <input type="radio"/> 055 MEASELS | <input type="radio"/> 319 MENTAL DISORDER | <input type="radio"/> 690 ECZEMA |
| <input type="radio"/> 072 MUMPS | <input type="radio"/> 345 EPILEPSY | <input type="radio"/> 716 ARTHRITIS |
| <input type="radio"/> 099 VENEREAL INFECTION | <input type="radio"/> 390 RHEUMATIC FEVER | <input type="radio"/> 724.2 LUMBAGO |

I STATE THAT THE HEALTH HISTORY GIVEN IS CORRECT. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY OR MY CHILD'S CONDITION AS HE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORIZATION FOR THESE PROCEDURES TO BE PERFORMED. I AGREE THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISTING MEDICALLY DIAGNOSED CONDITIONS NOR FOR ANY MEDICAL DIAGNOSIS.

X _____
PATIENT SIGNATURE AUTHORIZING CARE (Guardian, if a minor)

DATE _____



FINANCIAL/PAYMENT EXPLANATION

Welcome to Crane Chiropractic. We are very pleased to have you as a new patient and we are looking forward to showing you all the benefits chiropractic care can provide for you and your family. We would like you to understand our policy on payment agreements.

Please initial by payment method that applies to you.

CASH Initials: _____	Payment is due on the day charged. If you have a treatment plan that requires more that two visits per week, you may pay weekly. If you have problems staying current on your account, please see someone in the accounting department.
HEALTH INSURANCE Initials: _____	As a courtesy to you, we will file your insurance. We will verify coverage, ask for an explanation of benefits and file claims with assignment. Deductible and co-payments are due at the time the service is provided. It is important that our filing your insurance does not release you from the responsibility for the full charge. If your insurance has not paid within 60 days you will be asked to pay the amount due.
AUTO Initials: _____	We will file an auto insurance claim with assignment only. That means that the insurance company must be willing to pay the doctor directly. We will call for coverage and benefits. Filing insurance does not release you from the responsibility of the full charge. If your insurance company has not paid within 60 days you will be asked to pay the amount due.
PERSONAL INJURY Initials: _____	We will file an insurance claim with assignment only. The insurance must be willing to pay us directly. We will call for coverage and benefits. Filing insurance does not release you from responsibility of the full charge. If insurance has not paid within 60 days you will be asked to pay the amount due.
MEDICARE Initials: _____	We are a participating provider for Medicare and are under their rules and regulations. We will file Medicare on all charges. You will be asked to sign a "Medicare Waiver" which explains what Medicare will and will not pay on chiropractic charges. It is important to stay current with your percentage due. We do not file secondary or supplemental insurance. We only file Medicare, which is primary insurance.
MEDICAID Initials: _____	We are a participating provider for Medicaid and are under their rules and regulations. We will file Medicaid on all charges. You will be asked to sign a "Medicaid Waiver" which explains what Medicaid will and will not pay on chiropractic charges. It is very important that you stay current on any charges you may be responsible for.
MEDICARE/ MEDICAID Initials: _____	We will be filing to Medicare, which is primary. Medicare will forward the claim to Medicaid. Medicaid is the secondary for the 1 st 12 adjustments. After, you will be responsible for the 20% of the adjustment charge, in addition to any charges not covered by Medicare or Medicaid. You will be asked to sign a Medicare/Medicaid waiver for each visit to our office.
WORK COMP Initials: _____	We will file full charges on workers' compensation claims. We will call your employer for information and call the insurance company for benefits. You may be required to pay for items not covered by the insurance company.

If you have an attorney, we will need to know immediately. If you change attorneys during your care, we will need to know immediately. Failure to keep this office informed of any changes from your original payment status will result in default and you may be asked to pay your account in full. We do not enter into disputes with your health insurance carrier. We do not file secondary insurance policies. If for any reason, the responsible insurance carrier changes (for example, you originally say to bill health insurance and after we are fully reimbursed, we are told that work comp is responsible), **you will be charged \$15 for reprocessing your claim.**

All returned check(s) must be paid immediately with a \$25.00 cover charge. Please see the Accounting Office.

All accounts listed as past due may be filed to the credit bureau and/or turned over to a collection agency. In the event of default, the debtor becomes legally liable for any reasonable attorney and/or collection fees and all related cost necessary to collect the entire balance due to this office.

If you have questions concerning your care, please feel free to talk to Dr Crane. If you have questions concerning your account please fee free to talk to someone in the Accounting Office. We accept cash---checks---money orders---Visa---MasterCard---American Express---CareCredit.

X-RAYS: Due to state requirements, we must have all original x-ray films in our possession a minimum of seven (7) years. We can provide you with copies, if necessary, at an additional cost.

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION (“Agreement”)

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities (“payers”), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of Crane Chiropractic (“Office”) in the amount of the full charges incurred by me at the Office, past or future, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by be at the Office (“my charges”). I further grant a contractual lien to Crane Chiropractic with respect to my charges; however, I understand that nothing in this Agreement shall be construed as an election by Crane Chiropractic to claim protection under any statutory lien law. For the purposes of the Agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as proceeds relating to the following insurance coverage: individual/group health, disability, worker’s compensation, medical payment benefits, personal injury protection, lost wages, lost services, no-fault benefits, uninsured and underinsured motorist coverage, liability coverage and malpractice coverage.

I further agree that, in the event a payer refuses to pay Crane Chiropractic, I hereby assign to the Office, insofar as permitted by law, the following: all of my right, remedies, and benefits, to Crane Chiropractic, as well as any and all causes of action that might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office’s name, and the right to settle or otherwise resolve such causes of action as Crane Chiropractic sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to the Office regarding my charges. Upon issuance, I agree that such Letter(s) of protection cannot be revoked or modified without the expressed written consent of the Office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby authorize and direct Crane Chiropractic to file my claims with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g., liability, medpay, attorneys, etc.), I hereby authorize and direct Crane Chiropractic to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment.

I hereby direct all payers to release the Crane Chiropractic any pertinent information, regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release any information regarding my treatment or pertinent to by case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Crane Chiropractic to endorse/sign my name on any and all checks listing me as a payee that are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Crane Chiropractic to apply any credit balances on charges incurred by me to any other outstanding charges still owed by myself, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due Crane Chiropractic for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Crane Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Crane Chiropractic and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonable necessary for the protection of the rights and interests of Crane Chiropractic and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be finding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

By signing below, I agree, have read and understand Crane Chiropractic’s informed consent on the front and back of this page.

Patient Name (Please Print): _____ Date: _____

Patient Signature (Guardian, if a minor): _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPPA)

Please refer to form on office clipboard.

Initials: _____ I acknowledge that I was given the opportunity to read and ask questions regarding the **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**, which is effective as of the date signed and will expire six years after that date upon which the record was created.

C.A. Signature (office personnel): _____