Dr. Nicholas R. Reinholtz
Certified Chiropractic Sports Physician
Certified Acupuncturist

42 West Springer Drive
Highlands Ranch, Colorado 80126
(303) 471-9801 • FAX (303) 471-9802

Reinholtz Family Chiropractic

Confidential Patient Information

Name: _____ ❒ **F** ❒ **M** **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Date of Birth: _____ **SSN:** _____

Marital Status: ❒ **S** ❒ **M** ❒ **W** ❒ **D/Sep** **Name of Spouse:** _____

Place/Address of Employment: _____

Occupation: _____

How Did You Hear of Us? ❒ **Yellow Pages** ❒ **Newspaper** ❒ **Mailer Ad** ❒ **Other Ad**
❒ **Walk-in** ❒ **Web Site** ❒ **Other** ❒ **Referral (referred by):** _____

Emergency Contact Information

Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Billing Information ❒ CHECK HERE IF SAME AS PATIENT INFO ABOVE AND SKIP THIS SECTION

Name: _____ **Relationship to Insured:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Place of Employment: _____ **SSN:** _____

Insurance Information PLEASE PROVIDE YOUR INSURANCE CARD

Primary Policy Holder (name of insured)**:** _____

Insurance Company: _____ **Date of Birth:** _____

I.D. #: _____ **Group #:** _____

Secondary Policy Holder (name of insured)**:** _____

Insurance Company: _____ **Date of Birth:** _____

I.D. #: _____ **Group #:** _____

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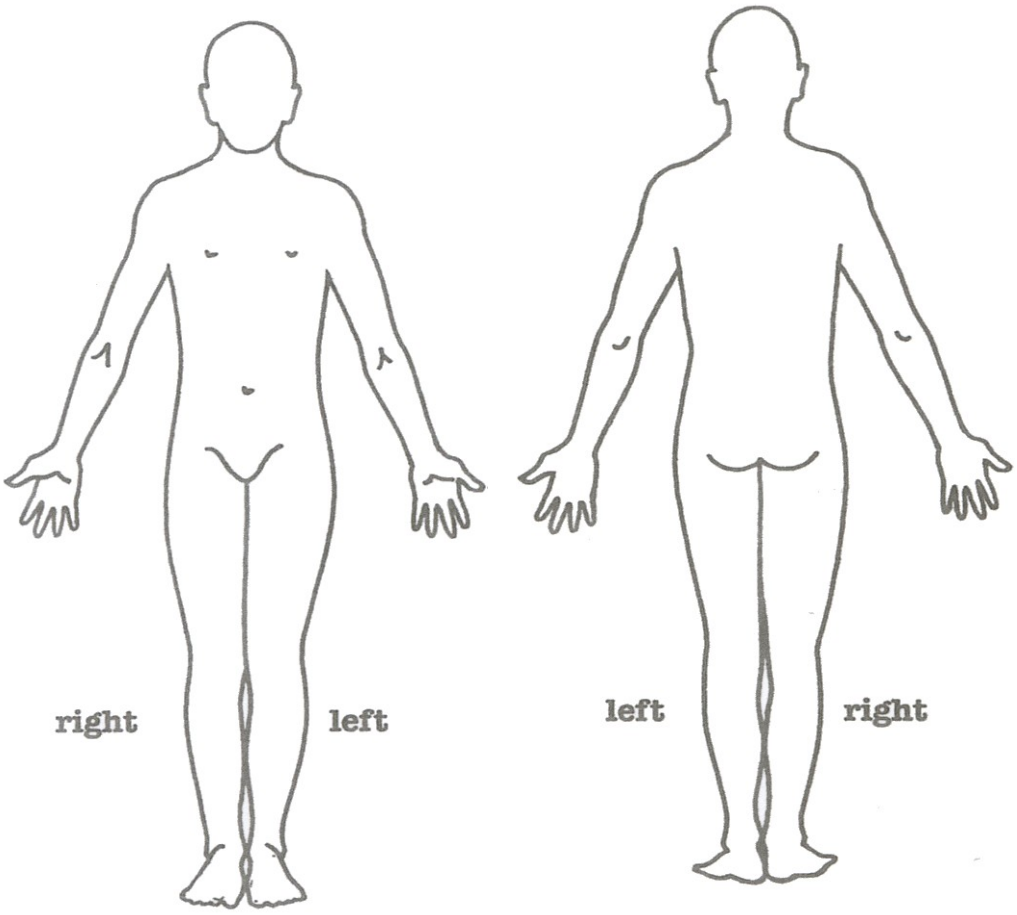
Name: _____ **DOB:** _____

Pain Diagram

Using the following symbols, indicate the area(s) of pain or unusual feeling. Mark all affected areas where you feel the described sensations, including areas of radiation.



XXXX NUMBNESS
/ / / / SHARP/STABBING
* * * * PINS & NEEDLES
0000 DULL/ACHEY
____ OTHER: _____

IF APPLICABLE, WHERE DOES THE PAIN RADIATE:

❒ SHOULDER(S) ❒ L ❒ R
❒ ARM(S) ❒ L ❒ R
❒ HIP(S) ❒ L ❒ R
❒ LEG(S) ❒ L ❒ R
❒ NECK ❒ L ❒ R
❒ SKULL/FACE ❒ L ❒ R

Pain Assessment

Assess and describe the pain below.

THE PAIN IS: ❒ MILD ❒ MODERATE ❒ SEVERE ❒ EXTREME

THE PAIN IS: ❒ CONSTANT ❒ INTERMITTENT ❒ OCCASIONAL

THE PAIN IS WORSE: ❒ MORNING ❒ EVENING ❒ FOLLOWING ACTIVITY ❒ ROUTINE ❒ MODERATE

THE PAIN INTERFERES WITH: ❒ WORK ❒ SLEEP ❒ PERSONAL ACTIVITY ❒ OTHER: _____

DESCRIBE WHAT MAKES THE PAIN BETTER OR WORSE:

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Name: _____ **DOB:** _____

Injury History

Describe your current major complaint *(i.e., when and how did it start, is it getting better or worse, etc.)*

EXPLAIN:

Additional symptoms noticed since the onset of this problem *(i.e., headache, blurred vision, loss of strength, trouble with bowel or bladder habits, etc.)*? ❒ YES ❒ NO

Have you sought treatment elsewhere or attempted to treat this problem yourself? ❒ YES ❒ NO

Have you had prior bone fractures or broken bones? ❒ YES ❒ NO

Have you had previous accidents, injuries, or surgeries? ❒ YES ❒ NO

Are you currently taking medications or over-the-counter drugs for this issue? ❒ YES ❒ NO

Do you have any other health problems or serious illnesses? ❒ YES ❒ NO

IF YES TO ANY OF THE ABOVE, EXPLAIN ON PAGE 6. BE SURE TO DETAIL ANY HEAD, NECK, AND BACK INJURIES AS WELL AS ANY SIGNIFICANT SPORTS OR MILITARY INJURIES.

FAMILY HISTORY

Does (or did) your Mother or Father have any of the following health issues or illnesses? Indicate with the following symbols: **M** for Mother, **F** for Father, and **B** for both.

_____ High Blood Pressure
_____ Heart Attack
_____ Emphysema
_____ Seizures-Convulsions
_____ HIV Positive
_____ Asthma
_____ Diabetes
_____ Kidney Disease
_____ Pacemaker
_____ Ulcer or Stomach Problems
_____ Stroke
_____ Arthritis-Rheumatism
_____ Mental Illness
_____ Thyroid Disease
_____ Circulation Problems
_____ Cancer
_____ Osteoporosis
_____ Other _____

COMMENTS:

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Treatment Authorization Record

Name: _____ **DOB:** _____

Consent for Release of Information/Patient Notification Statement INITIAL EACH

_____ I hereby authorize *Reinholtz Family Chiropractic* and/or its employees to release to employer groups, insurance companies, government agencies or other third party payers and their agents information concerning medical care, advice, treatment, or supplies or other information that may be necessary for the chiropractic care service provided to me. This authorization may be revoked in writing at any time except as to those actions which may have already occurred.

_____ I understand that the care and services I will receive at *Reinholtz Family Chiropractic* are subject to review by healthcare professionals, third party payers, and review agencies.

_____ I understand that I will be financially responsible for all charges incurred for my treatment if my revocation or refusal to authorize the disclosure of my medical records results in payment denial of my insurance claim(s).

Payment Guarantee/Assignment of Insurance INITIAL THE OPTION THAT APPLIES

_____ I represent that I presently maintain medical insurance coverage, which will directly reimburse *Reinholtz Family Chiropractic (RFC)* the charges for the chiropractic care being provided. If my medical coverage is not sufficient to satisfy the chiropractic charges in full, I acknowledge that I am fully responsible for payment of this balance, due immediately for the chiropractic care rendered, and I agree to pay the established rates of *RFC* for all services and supplies rendered.

_____ I represent that I presently maintain medical insurance coverage, which will directly reimburse to me directly the charges for the chiropractic care provided, and I will reimburse *RFC*. In consideration of those chiropractic services rendered by *RFC*, I hereby assign to *RFC* all of my rights to medical reimbursement, including but not limited to the right to designate a beneficiary, add dependent eligibility, and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate, or other health benefit indemnification agreement otherwise payable to me for those services rendered by *RFC*.

_____ As I do not maintain medical insurance for which benefits are payable for chiropractic care, I agree to be fully responsible for the payment of all charges for all services rendered by *RFC*, and I understand that all charges are payable immediately.

If required, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection. In the event that the balance due remains unpaid for more than 120 days, I agree that all attorney's and collection fees that do not exceed one-third of the balance due are reasonable and agree to pay same.

_____ _____

Signature of Policy Holder Signature of Patient

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Missed Appointment Fee

I, _____ hereby acknowledge that at any time I have an appointment scheduled with Dr. Reinholtz and I fail to appear for that appointment without calling to cancel at least two hours prior, **I will be charged a missed appointment fee of $25.00**.

Should I fail to comply with this agreement, I understand that I will not be permitted to schedule another appointment until the missed appointment has been paid in full.

My signature below signifies my understanding and compliance with this policy.

_____ _____
Signature of Patient (or Representative) Printed Name of Patient

_____ _____
(Representative's Authority) Date of Signing

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COMMENTS / NOTES

Use this page, if necessary, to provide additional details about any of the information you supplied in this packet.