COMPREHENSIVE PAIN CLINIC OF PORTLAND

CONFIDENTIAL PATIENT INFORMATION

Please answer all the questions completely. All information provided is strictly confidential. If you do not understand a question or are unsure of the information, please ask for assistance.

Name: _____Date:_____

Address: _____City:_____State:_____Zip:_____

DOB: ____/____/____ Age: _____ Home Phone: _____Cell Phone_____

Email: _____ Marital Status: M S W D

Name of Spouse: _____Children (#):_____

Emergency Contact: _____ Relation: _____

Address: _____Phone: _____

Referred by: _____

EMPLOYMENT INFORMATION

Occupation: _____Employer:_____

Work Address:_____Work Phone:_____

Spouse Occupation:_____Employer:_____

Work Address:_____Work Phone:_____

INSURANCE INFORMATION

Name of Insurance Co.:_____Name of Insured:_____ID#_____

Address:_____Phone:_____

Is condition due to injury/illness arising from employment? Yes No

Date symptoms occurred or accident happened:_____

Have you lost any days from work? Yes No How many?_____Date last worked?_____

MEDICAL INFORMATION

Date of last physical exam: _____Are you pregnant?_____

What operations have you had? _____

Serious illnesses:_____

Ever been under Chiropractic Care? Yes No Dr.'s Name:_____

Have you ever suffered from: (Please mark all that apply)

Alcoholism	Allergies	Anemia	Arthritis	Asthma	Breast Lump
Breathing Problems	Bruise Easily	Bursitis	Cancer	Colon Trouble	Cramps
Deafness	Depression	Diabetes	Diarrhea	Digestion Problems	Dizziness
Fatigue	Hay Fever	Headaches	Heart Pain	High BP	Hot Flash
Itching	Kidney Inf.	Low BP	Nausea	Nervousness	Nose Bleed
Poor Posture	Poor Circulation	Prostate	Sciatica	Sinus Infection	Sleep loss
Spinal Curve	Stroke	Swollen Joints	Thyroid	Tuberculosis	Ulcers
Varicose Veins	Other:_____				

Tingling/Numbness in:

Shoulders Hips Arms Legs Elbows Knees Hands Feet

6915 SW MACADAM AVENUE, SUITE 102 / PORTLAND, OR 97219 / TEL.: (503) 244-3389 FAX: (503) 244-4855

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HABITS	HEAVY	MODERATE	LIGHT	NONE
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

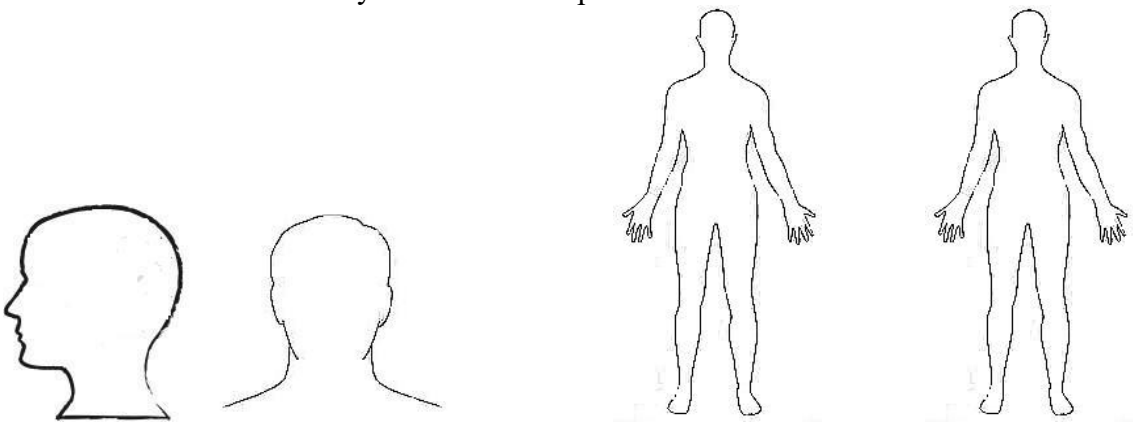
Do you take Vitamins or Minerals? Yes No

Do you think you may need Vitamins or Minerals? Yes No

Are you currently wearing: Heel lifts
Sole lifts
In-soles
Arch Supports

Purpose of this appointment? (Major Complaint):_____

Please indicate the areas of your current complaints:



Front Back

What activities aggravate your condition?_____

Is this condition getting progressively worse? Yes No Constant Comes and Goes

Is this condition interfering with your: Work Sleep Daily Routine

Other_____

How long has it been since you really felt good?_____

What do you believe is wrong with you?_____

Other Doctors seen for this condition?_____

Have you been treated for any condition by a physician in the last year? Yes No

Describe:_____

What medications or drugs are you currently taking?_____

Remarks and additional information:_____

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Financial Policy

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. I give this office power of attorney to endorse checks made out to me, to be credited to my account. I authorize the physician to release any information that is required or necessary for my claim

If you have insurance that has benefits for chiropractic care, you have two payment options.

1. You can pay for each office visit in full at the time service is rendered. We will give you a receipt to attach to your insurance form.
2. Once your deductible has been met, a co-payment for each visit is required. As a courtesy to our patients, we will file on all available insurance policies and wait for payment of any outstanding balance.

In the event of no insurance coverage, payment is required at the time service is rendered. Credit and debit cards, cash, or checks are accepted.

Injuries resulting from automobile or work-related accidents are typically paid for in full by insurance carriers. As a courtesy to our patients, we will wait for payment directly from the insurance company. If you receive payment from the insurance company, that check must be brought to this office and applied to the balance.

Your insurance coverage is a contract between you and your insurance company, not between the doctor and the insurance company. We only accept assignment as a courtesy to you. However, all services rendered are charged directly to you, the patient, and you are ultimately responsible for payment.

Any suspension or termination of the patient will result in forfeiting the courtesy we extended on waiting for payment with the balance of all services rendered due to and payable immediately.

If you need to cancel an appointment, please provide 24-hour notice. Cancelation with less than 24-hour notice or no-shows will be charged $90.

I do believe that a clear definition of our policies will allow us to concentrate on the big issue – regaining and maintaining your health. If you have any questions, please contact our office at 503-244-3389.

Please sign, indicating that you have read and understand the above stated policies.

Patient's Signature (or Responsible Party) Date

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