

WELCOME
to
Levinson Family Chiropractic

PATIENT INFORMATION:

Thank you for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ Soc. Sec. # _____

Street Address _____ City _____ State _____ Zip _____

Sex: Male Female Birth Date _____ Age _____

Phone # _____

Email Address _____

Are you: Minor Married Divorced Widowed Single Separated

Occupation: _____ Your Employer: _____

Business Address: _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

RESPONSIBLE PARTY: _____ **If same as patient information, check here.**

Name of person responsible for this account? _____ Soc. Sec. # _____

Relationship to patient _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # _____

For your convenience we offer the following methods of payment. Please check the option you prefer. Co-payments, deductibles and cash patient payments are expected to be paid at the time of service.

Insurance. Name of Insurance Company _____

Cash Personal Check Credit Card

SYMPTOMS:

Reason for visit _____

When did you first notice the symptoms? _____

Is your condition getting progressively worse? yes no unknown

Type of pain (check all that are applicable):

Sharp Dull Throbbing Numbness Aching Shooting Burning

Tingling Cramps Stiffness Swelling Other, please describe _____

Rate the severity of your pain (1, mild pain/discomfort, to 10, severe pain/ discomfort): _____

Is the pain/discomfort constant or does it come and go? _____

Which activities are difficult to perform: Sitting Standing Walking Bending Lying down

Does it interfere with your: Work Sleep Daily Routine Recreation

What treatment have you already received for your condition?

Medication, please list _____

Surgery Physical Therapy Other, _____

Name, City and State of other doctors who have treated you for your condition _____

HEALTH HISTORY (Check if you have had any of the following, list dates):

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fracture | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other, _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | |

Dates of last medical/chiropractic exams: _____

(Women) Are you pregnant? No Yes, how long? _____ Nursing? Yes No

Taking Birth Control Pills? Yes No

List any types of surgeries you have had and the date which they occurred: _____

Please list all of the medication you are currently taking: _____

Allergies? _____

DAILY HABITS:

What type of exercise do you perform? None Moderate Heavy Weight training? Aerobic?

What do your daily habits include? (e.g. Sitting, standing, light labor, heavy labor, computer work, phone) _____

What vitamins do you currently take? _____

Do you smoke? No Yes How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages (soda) do you consume on a daily basis? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such health care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or medical group insurance benefits otherwise payable to me. I understand that my health insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependants.

Signature of patient/parent/guardian _____

LEVINSON FAMILY CHIROPRACTIC
DR. PAMELA L. LEVINSON
DR. JOHN T. CONNERY
646 PORTAGE TRAIL
CUYAHOGA FALLS, OHIO 44221

Dear Patient,

We know that it is difficult to talk about finances when you are ill or in pain. But there are several things that must be understood.

Your insurance coverage is a contract between you and your insurance company, not between the insurance company and your doctor. You individually are always primarily responsible for your bill. We will make every effort to receive collection and or reimbursement from the insurance company. If your insurance company does not pay, you are responsible for your bill and will receive a statement.

We belong to many different insurance companies. However, we are not included in all of the programs. For example, some insurance companies such as Aetna, Anthem and Medical Mutual of Ohio have different programs. Therefore, check in your provider booklet to verify our inclusion in your specific program.

You should also call your insurance company to verify your coverage for deductibles, co-pays, and percentage of payment on Chiropractic benefits specifically. Our office will also call. Sometimes we the provider and you the member are given the wrong information regarding coverage, that is why it is important that we both call.

If you have any questions or you are having problems with your insurance company feel free to ask us and we will try to get accurate information from your insurance company. We will attempt to get payment, with your help, and get your maximum benefit.

Signature: _____ Date: _____