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 ______

Home Phone # _______________ Work Phone # _____________

Do you prefer to receive call at: __ Home __ Work __ Either

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

— OVER—

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):

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

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:_________________