Monticello
Chiropractic & Therapy
212 Cedar St Monticello, MN 55362 Ph: (763) 295-2262
www.monticellochiropractic.com admin@monticellochiropractic.com

Patient Information Form

DATE_____

PATIENT'S NAME_____ DATE OF BIRTH_____
Full First Middle Last

MALE___FEMALE___ E-MAIL_____ SOCIAL SECURITY #_____

ADDRESS:ST_____CITY_____STATE_____ZIP_____

PHONE (HOME)_____(CELL)_____

EMPLOYER_____ WORK PHONE_____

ADDRESS:ST_____CITY_____STATE_____ZIP_____

NAME OF INSURANCE_____EFFECTIVE DATE_____CO-PAY$_____

NAME OF POLICY HOLDER_____POLICY HOLDER'S DATE OF BIRTH_____

RELATIONSHIP TO POLICY HOLDER: SELF____SPOUSE____DEPENDENT____

NAME OF AN EMERGENCY CONTACT_____PHONE #_____

HOW DID YOU HEAR OF OUR OFFICE_____

WHO REFERRED YOU TO OUR OFFICE_____

I HEREBY AUTHORIZE, FROM THIS DAY FORWARD, ANY INSURANCE COMPANY WHOM I SUBSCRIBE WITH TO PAY DIRECTLY TO MONTICELLO CHIROPRACTIC & THERAPY (MC&T) CHARGES FOR SERVICES RENDERED. I AUTHORIZE MC&T TO DISCLOSE INFORMATION NECESSARY TO: MY HEALTH INSURANCE COMPANY, AND IN THE CASE OF A WORKER'S COMPENSATION CASE OR AUTO ACCIDENT, TO THOSE PARTICULAR INSURANCE COMPANIES. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES MADE TO ME AND/OR MY FAMILY'S ACCOUNT, INCLUDING ALL NON-COVERED SERVICES, DEDUCTIBLES, AND CO-PAYMENTS. IF AN ACCOUNT BECOMES DELINQUENT AND A COLLECTION AGENCY AND/OR LAW OFFICE IS NEEDED TO COLLECT ON THE ACCOUNT, I UNDERSTAND I AM RESPONSIBLE FOR ALL COLLECTION COSTS AND/OR ATTORNEY FEES. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY MC&T OF ANY CHANGES PERTAINING TO MY INSURANCE COVERAGE AND/OR MY ACCOUNT.**

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
SIGNATURE OF PARENT, GUARDIAN, OR REPRESENTATIVE OF PATIENT UNDER 18 **DATE**

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DESCRIBE YOUR CURRENT HEALTH PROBLEM _____

_____

LIST ANY OTHER HEALTH PROBLEMS YOU ARE CURRENTLY EXPERIENCING/BEING TREATED FOR

_____

CHECK ALL THAT YOU ARE PRESENTLY EXPERIENCING, AND CIRCLE ANY YOU HAVE HAD PREVIOUSLY

GENERAL

___DIZZINESS OR FAINTING
___FATIGUE
___FEVER
___HEADACHES
___LOSS OF SLEEP
___NUMBNESS
___WEAKNESS IN ARMS/LEGS

EENT

___ASTHMA
___HEARING LOSS
___EAR PAIN
___FREQUENT COLDS
___HAY FEVER
___HOARSENESS
___NASAL CONGESTION
___NOSE BLEEDS
___SORE THROATS/TONSILITIS

GASTRO-INTESTINAL

___BELCHING OR GAS
___COLITIS
___COLON TROUBLE
___DIARRHEA
___GALL BLADDER
___LIVER OR JAUNDICE
___NAUSEA
___PAIN OVER STOMACH
___POOR APPETITE
___VOMITING
___VOMITING BLOOD

WOMEN ONLY

___**ARE YOU PREGNANT?**
___PAINFUL MENSTRATION
___MENSTRUAL BACKACHE
___MENSTRUAL CRAMPS
___LUMPS IN BREASTS
___ MENOPAUSAL SYMPTOMS
___HOT FLASHES

RESPIRATORY

___CHEST PAIN
___CHRONIC COUGH
___DIFFICULT BREATHING
___SPITTIING UP BLOOD

GENITO-URINARY

___BLOOD IN URINE
___FREQUENT URINATION
___INABILITY TO CONTROL URINE
___KIDNEY STONES
___KIDNEY INFECTIONS
___PAINFUL URINATION
___PROSTATE TROUBLE

MUSCLE AND JOINT

___NECK PAIN
___MID BACK PAIN
___LOW BACK PAIN
___ARM/HAND PAIN
___LEG/FOOT PAIN

CARDIO-VASCULAR

___HARDENING OF ARTERIES
___HIGH B/P
___PAIN OVER HEART
___PREVIOUS STROKE
___ANKLE SWELLING

FAMILY HISTORY

___CANCER
___HEART DISEASE
___HIGH B/P
___DIABETES

HAVE YOU HAD ANY

___ARTHRITIS
___CANCER/TUMOR
___GOITER
___HEART DISEASE
___UNUSUAL WEIGHT LOSS/GAIN
___OSTEOPOROSIS

HAVE YOU HAD ANY SURGICAL PROCEDURES OR BEEN HOSPITALIZED? ___YES ___NO

IF YES, EXPLAIN_____

WHAT TYPE OF REGULAR EXERCISE DO YOU PERFORM? ___NONE___LIGHT___MODERATE___STRENUOUS

WHEN WAS YOUR LAST: COMPLETE PHYSICAL_____ B/P CHECK_____ANY X-RAYS_____

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Preferred Language: English (circle) Other:_____

Race:

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Patient Declined to Provide

Ethnicity:

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Patient Declined to Provide

Smoking Status:

- ○ Current Every Day Smoker
- ○ Current Some Day Smoker
- ○ Former Smoker
- ○ Never Smoker

List Active Medications and Reason for Taking: (If none/unknown, please specify):

_____

_____

_____

Medication Allergies: (If none/unknown, please specify):

_____

_____

_____

Height: Feet _____ Inches _____

Weight: _____

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Notification of Policies Received & Reviewed

Informed Consent

I have read or have had read to me, the explanation of the chiropractic adjustment and related treatment. I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care.

Signature:_____ Date:_____

Signature of Parent or Guardian if Patient under 18:_____

Privacy Policy and Patient Consent for Chiropractic Treatment

I, _____ have received a copy of Monticello Chiropractic & Therapy's Privacy Practices in accordance with HIPAA, and have been provided an opportunity to review it. Additionally, I consent to all of the uses and disclosures mentioned in the Consent to Release of Information section of the Patient Consent for Chiropractic Treatment form. I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here: _____

Signature:_____ Date:_____

Signature of Parent or Guardian if Patient under 18:_____

Signature on File

I hereby request that payment of authorized benefits be made to Monticello Chiropractic & Therapy for services provided to me. I understand that any portion unpaid or denied by my insurance company is my responsibility and will be paid by me to Monticello Chiropractic & Therapy. I authorize the release of any information that the provider may require to determine the benefits payable. I permit a copy of this authorization to be kept on file and used in place of the original.

Signature:_____ Date:_____

Signature of Parent or Guardian if Patient under 18:_____