David M. Warwick, D.C. · Warwick Chiropractic, PLLC
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PATIENT HISTORY INTAKE / UPDATE

Name_____Date_____

Address_____

City_____State_____Zip_____

SS# _____Date of Birth_____ Age _____Marital Status S M D W

Primary/Cell #_____ E-Mail _____

How were you referred? _____Occupation_____

Primary Care Provider Name _____Phone # _____

Is the Condition: AUTO RELATED JOB RELATED HOME INJURY SLIP/FALL LIFTING SLEPT WRONG
UNKNOWN CAUSE OTHER EXPLAIN: _____

PATIENT METHOD OF PAYMENT: CASH/CREDIT INSURANCE MEDICARE WORK COMP PIP (AUTO INS)

(PLEASE PROVIDE YOUR UPDATED INSURANCE & DRIVER'S LICENSE/IDENTIFICATION)

Our office will provide insurance billing services for you as a courtesy. Your health insurance benefits are based on a contract between you and your health insurance carrier and any benefits quoted are not a guarantee of payment. I authorize direct payment of medical benefits, from my insurance company to Dr. David M. Warwick, Warwick Chiropractic, or supplier for any services performed at this office. I also authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party that accepts assignment.

It is understood that all reasonable efforts will be made to collect from my insurance company, and final determination of payment will only be made after claims have been received and processed. I understand that any and all amounts which are not collected from my insurance company shall become my responsibility, and I agree to pay those charges within 30 days. I further agree that any insurance reimbursement check that I receive directly from the insurance company (usually if Dr. Warwick is out of network), shall be transferred to Dr. David Warwick in full within 10 days of my receipt of the check. If I owe a deductible or co-pay for my treatment, I agree that I shall make all reasonable efforts to pay at time of service unless otherwise agreed upon. I understand that it is my responsibility to pay any deductible amount, copays, coinsurance, and / or any other balances that are not covered by my contract or paid by my insurance carrier.

I understand that motor vehicle accidents and workers compensation cases with outstanding balances after one year will be charged 12% interest fee annually. I also understand I am responsible for lien fees associated with filing medical liens with the court.

I acknowledge that I have received the practice's Notice of Privacy Practices for protected health information.

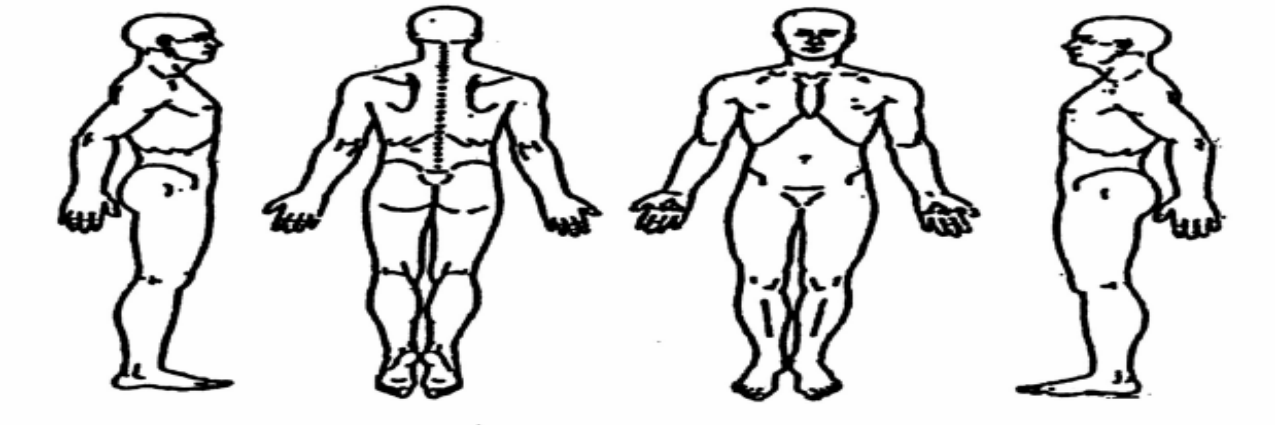
Signature: _____Date:_____

ChiroTrust™

As a member of ChiroTrust™, our office has taken The ChiroTrust Pledge™ to provide our patients convenient, affordable, and mainstream Chiropractic Care without any unnecessary long-term treatment plans and/or therapies. For more information on Chiropractic and ChiroTrust™, visit www.Chiro-Trust.org Thank you. Dr. David Warwick

TURN OVER >>>>>

******Circle & Mark ALL Areas of Complaint or Concern & Rate Severity (1 to 10):**



NECK MIDBACK LOW BACK (SI) SACROILIAC HEADACHE(S)/MIGRIANES RADICULAR / SCIATIC PAIN

UPPER EXTREMITY: SHOULDER / ARM / ELBOW / HAND LOWER EXTREMITY: THIGH / LEG / KNEE / FOOT

Types of Symptoms: Burn Dull Ache Sharp Shooting Throbbing Stabbing Swelling Spasms Tension

Numbness Tingling Electric-Like Pins & Needles Other_____

How often do you experience these symptoms?

Constant (75-100% of the time) Frequent (51-75% of the time) Occassional (26-50% of the time) Intermittant (0-25% of the time)

When did the pain / injury begin? _____ Describe injury:_____

Are the symptom(s) getting: BETTER SAME WORSE NO CHANGE _____

What AGGRAVATES your condition? _____

What RELIEVES your condition?_____

What therapies have you tried? _____

What prescription / OTC medications are you currently taking? _____

Past traumas / hospitalization / past medical history:_____

_____

Other questions or concerns: _____

_____

DOCTOR'S NOTES:

HEIGHT_____ WEIGHT_____ BMI_____ BLOOD PRESSURE_____/_____mm/Hg PULSE_____BPM

BALANCE TEST(S)_____/_____LBS - EYES OPEN/EYES CLOSED/LEG RAISED – LT RT ARM(S) _____