Nicolai Chiropractic Center - Refresher Form

PLEASE PRINT ***Use Legal Names - no nicknames*** Date:_____

Last Name_____First_____M.I._____Soc.Sec.#_____

Mailing Address_____City/State_____Zip_____

Preferred name or nickname _____ Age:____Birth Date:_____Gender: M F Marital Status: M S W D

Would you like to receive our monthly newsletter? Yes No Email address_____

Home Phone:_____Cell Phone:_____

Occupation:_____Employer:_____Wk.Phone:_____

Employer Address: _____

Spouse's Name:_____Spouse's Birth Date:_____ Soc. Sec. #_____

Spouse's Employer:_____Employer Address_____Phone#_____

List household members who are patients here:_____

Medicare No._____Full Name on Card_____

Insurance Co._____Policy#_____Policy holder Name_____

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Who Were You Referred By_____

Child: Father's Name: _____Father's Soc Sec #: _____Father's Birthday _____

Father's Employer:_____Employer Address:_____Phone#: _____

Mother's Name:_____Mother's Soc Sec#**:**_____Mother's birthday_____

Mother's Employer:_____Employer Address:_____Phone#:_____

Chief Area of Complaint:_____Date Symptoms Started:_____

Describe your problem_____

What Makes Your Condition Worse?_____

Is This Condition: ❑Constant ❑ Progressively worse ❑ Comes and goes?

Does This Condition Interfere With: ❑ Work ❑ Sleep ❑ Daily routine?

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

Have you seen other doctors for this condition? _____ If yes, when & who?_____

Have you ever been under chiropractic care?_____ If yes, when & who?_____

Have you ever experienced any numbness or tingling? _____If yes, where?_____

How long did the numbness or tingling persist? _____

Is This Condition Due To an Injury? Yes No Employment Related?_____ Auto Accident?_____ Personal Injury?_____

Accident Date:_____Please describe how this happened_____

_____

Have you filed a claim? Yes No Have you had prior work related claims? Yes No What body area was affected?_____

Are prior claims: Open _____ Closed _____ Unsure _____ Have you ever had the same or similar condition? Yes No

If Yes, describe_____

Last physical exam_____ If female, are you pregnant? _____

List surgeries you have had_____

Fractures_____

List serious illnesses_____

What medications or drugs are you taking?_____

_____

Remarks/comments

_____

_____

Do you use:	Heavy	Moderate	Light	None
Alcohol	❒	❒	❒	❒
Coffee	❒	❒	❒	❒
Tobacco	❒	❒	❒	❒
Exercise ❒	❒	❒	❒	
Water Intake	❒6-8 glasses	❒4-6 glasses	❒1-4 glasses	❒

Please turn the page over

Consent ❖ Release of Information ❖ Financial Policy ❖ Truth of Information

I authorize Dr. Nicolai/Dr. Weber and whomever he may designate as his assistants to perform Chiropractic adjustments, treatments, and procedures upon (patient name) _____. I further consent to X-ray examination, laboratory procedures, consultations, and diagnostic procedures rendered in conjunction with Chiropractic care.

I authorize the release information from the patient's records to doctors, hospitals, or others for continuous care and to any third party who requires information in order to fulfill an obligation benefitting the patient. I authorize payment to Nicolai Chiropractic from the patient's insurance company(s) and/or Medicare.

Nicolai Chiropractic Center accepts most insurances. We will process insurance claims and send them to the respective company(s). However, co-payments are due at the time of service. I understand that I am responsible for the balance of the account that insurance does not cover.

Medicare patients: I understand that Medicare does *not* cover X-ray examinations, physical examinations, extremity adjustments, hot or cold treatments, traction or other therapies performed by a Chiropractor. Medicare will only cover chiropractic spinal adjustments. Medicare, in some cases will allow up to 12 visits per year. If, in some instances, Dr. Nicolai feels that more treatments are necessary he may apply for additional treatments. Medicare does not cover the cost of supplements often suggested as treatment by chiropractors. If x-rays, physical exams, therapies, or supplements are required, and supplemental insurance does not cover these services, I understand that I am responsible for these charges.

Accidental Policy Holders: (Combined, Capitol America, AFLAC etc.) You must fill out your portion of the accident report form. Our portion will then be completed. ***You must notify us at the time of your visit so a record of the accident becomes part of your medical record.*** If accident information is not part of the medical record, your insurance company may deny your claim. Total disability will be declared only by the Doctor and will be noted in your chart.

Patients with no Chiropractic coverage: Full payment is due at the time of service. If full payment cannot be made at the time of service, please ask the receptionist about our payment plan.

Supplements must be paid for at the time of purchase.

I have truthfully answered all questions to the best of my ability and consent to treatment. I have read and fully understand the financial policy of Nicolai Chiropractic Center and agree to the terms therein.

_____ _____

Patient, Parent, or Legal Guardian Signature Date