Center for Life Chiropractic & Wellness
1004 NW Milwaukee Ave. #200
Bend, OR. 97703
541-312-9794

Title: (Circle one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _______

First Name __________________ Middle Initial ____ Last Name _________________________

Address ____

City ______________________________ State __________________ Zip Code _____________

Leave Messages on (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) ________-___________ Work Phone (_____) _________-____________

Cell Phone (_____) ________-___________Email __________________________________

Date of Birth _____/_____/______ **Sex:** ☐ Male ☐ Female ☐ Other

Weight (lb.) _______ Height (ft.) ____________

Social Security Number**:** ______-_____-______ Marital Status**:** ☐ Single ☐ Married ☐ Other

Employment Status**:** ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data ____

Employer ____

Your Occupation ____

Spouse Data____

First Name _______________________ Middle Initial ____ Last Name ____________________

Home Phone (_____) _______-__________ Work Phone (_____) _______-____________

Spouse Date of Birth _____/_____/_______

Emergency Contact____

Contact Name ____________________________ Relationship to Patient ___________________

Contact Home Phone (_____) _______-________ Cell Phone (_____) ________-______________

Doctor's Signature ____

How did you hear about our office? ____

Medical Conditions: (Circle all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _____________	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐Breast Augmentation	Other _____________		

Allergies: (Circle all that apply to you)

☐ Mold	☐ Seasonal	☐ Milk or Lactose	☐ Animal
☐ Chemical __________	Sulfites	☐ Wheat/Glutens	☐ Other _________

Social History: (Circle all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Drink Water:	☐ <64 oz/day	☐>64 oz/day	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never
Sleep:	☐<8 hours/night	☐ >=8 hours/night	Insomnia ☐

Other ________________

Family History: (Circle all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other _________________

Occupational Activities: (Circle one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper
☐ Other ________________			

Doctor's Signature ____

Patient Name____Date___________________

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken ____

____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

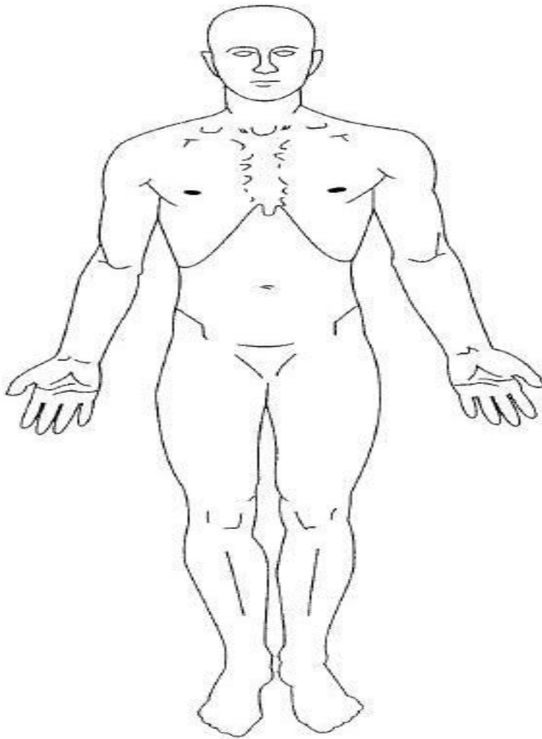
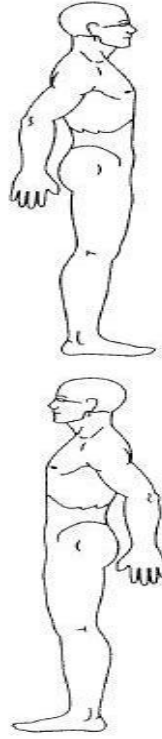
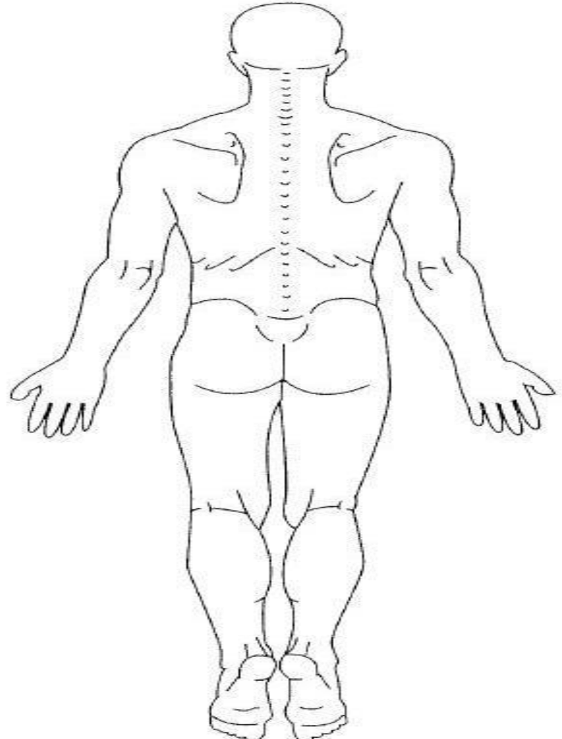
Are You Pregnant**?** ☐ Yes ☐ No

Doctor's Signature ______________________________________

Patient Name____Date____________________

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache

Average Pain Intensity**:**

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes **No** **If Yes, please list:**

When did your symptoms begin? ____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

How did your symptoms begin? ____
____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Ache ☐ Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Throbbing ☐ Other ______

Doctor's Signature ____

Patient Name____Date______________________

PAYMENT POLICY

Thank you for choosing Center for Life Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to charge $25.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

Signature of patient/responsible party____________________________ Date_______________

The following are authorizations regarding informed consent, privacy practices acknowledgement, and permissions under the HIPPA act.

THE PERSON IDENTIFIED AUTHORIZES CENTER FOR LIFE CHIROPRACTIC, P.C. TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

1. Notice of privacy practices acknowledgement: I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

2. I give permission to Center for Life Chiropractic, P.C. to use my name, address and phone number to contact me with appointment reminders, missed appointments, greeting cards, as well as information about chiropractic care.

3. If Center for Life Chiropractic, P.C. contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

4. I give Center for Life Chiropractic, P.C. permission to adjust me within an open-air room where other people are also being adjusted. I am aware that other persons in the office may overhear some of my health information and casual conversation during the course of care. If I need to speak with the doctors at any time in private, the staff will provide a room for these conversations. I also consent to signing the guest book every time and understand that it may be in view of others.

5. If you have insurance benefits and elect to use these benefits, we will use your information to process your insurance claims electronically, by fax or by mail. The following release gives permission to use your information to process your claim. I also authorize payment of medical benefits to Center for Life Chiropractic, P.C. for services rendered.

6. By signing this form you are giving Center For Life Chiropractic, P.C. permission to use and disclose your health information in accordance with the directives listed above.

EXPIRATION

The Authorization is effective as of January 1, 2020. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Center for Life Chiropractic, P.C. The written notice must contain the following information:

- Your name, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request: and your signature

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Center for Life Chiropractic, P.C. will still provide service to you.

Signature ____ Date ______________________
If a minor, or represented by another party
Signature of Personal Representative ______________________________________

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OFFICE: 541.312.9794 FAX: 541.312-9795
DR. JASON A. FRIEDMAN, D.C.