Health Record # __________

# Alexander Chiropractic Center

22930 Three Notch Rd, California, MD 20619 * 301-737-4007
14350 Solomons Island Rd, Suite 103A, Solomons, MD 20688-1269 * 410-394-1000

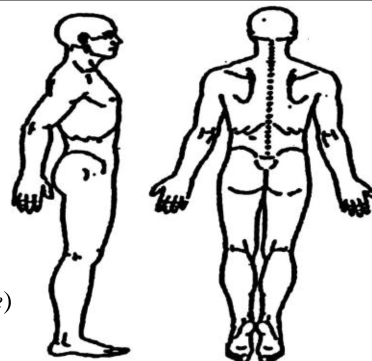
# Confidential Health Questionnaire

**Patient Name**: ______________________________ **Date of Birth:** ______________ **Date**: _____________

Present Complaint(s): ____________________________________________________________________________

1. Have you ever been in an automobile accident? □ No □ Yes, when________________________________________

2. Have you ever been injured at work? □ No □ Yes, when________________________________________________



3. Indicate on the drawings below where you have pain/symptoms:

4. Please select all that apply: □Sharp □Dull □Achy □Burning □Stiff
□Numbness □Shooting □Tingly □Radiating □Soreness □Stabbing □Other
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. Intensity of your symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) (*Please circle*)

6. How do you think your problem began?_______________________________________________________

7. How long have you had this problem? ___________ days _________ months ________ years

8. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

9. What aggravates your problem?_____________________________________________________________

10. What alleviates your problem?_____________________________________________________________

11. Have you had this problem before? _________________________________________________________

12. How much has the problem interfered with your work?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

13. How much has the problem interfered with your sleep?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

14. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

15. This problem prevents me from:____________________________________________________________

16. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician □ No one
□ ER physician □ Orthopedist □ Physical Therapist □ Other: _____________

17. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

18. What level of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Health Record # __________

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

| Past | Present | Past | Present | Past | Present |
|---|---|---|---|---|---|
| □ | □ Headaches | □ | □ High Blood Pressure | □ | □ Diabetes |
| □ | □ Neck Pain | □ | □ Heart Attack | □ | □ Excessive Thirst |
| □ | □ Upper Back Pain | □ | □ Chest Pains | □ | □ Frequent Urination |
| □ | □ Mid Back Pain | □ | □ Stroke | □ | □ Smoking/Tobacco Use |
| □ | □ Low Back Pain | □ | □ Angina | □ | □ Drug/Alcohol Dependence |
| □ | □ Shoulder Pain | □ | □ Kidney Stones | □ | □ Allergies |
| □ | □ Elbow/Upper Arm Pain | □ | □ Kidney Disorders | □ | □ Depression |
| □ | □ Wrist Pain | □ | □ Bladder Infection | □ | □ Systemic Lupus |
| □ | □ Hand Pain | □ | □ Painful Urination | □ | □ Epilepsy |
| □ | □ Hip Pain | □ | □ Loss of Bladder Control | □ | □ Dermatitis/Eczema/Rash/skin condition/acne |
| □ | □ Upper Leg Pain | □ | □ Prostate Problems | □ | □ HIV/AIDS |
| □ | □ Knee Pain | □ | □ Abnormal Weight Gain/Loss | □ | □ STD'S |
| □ | □ Ankle/Foot Pain | □ | □ Loss of Appetite | □ | □ Thyroid Problems |
| □ | □ Jaw Pain | □ | □ Abdominal Pain | □ | □ Excessive Fatigue |
| □ | □ Joint Pain/Stiffness | □ | □ Ulcer | □ | □ Unusual Hair Growth |
| □ | □ Arthritis | □ | □ Hepatitis | □ | □ Hair Loss |
| □ | □ Rheumatoid Arthritis | □ | □ Liver/Gall Bladder Disorder | □ | □ Inability to Loose/Gain Weight |
| □ | □ Cancer | □ | □ General Fatigue | □ | □ Excessive Mood Swings |
| □ | □ Tumor | □ | □ Muscular Incoordination | □ | □ Hot Flashes or Night Sweats |
| □ | □ Asthma | □ | □ Visual Disturbances | □ | □ Mental Fog |
| □ | □ Chronic Sinusitis | □ | □ Dizziness / Mental Fog | | |
| □ | □ Other:___________________________ | | | | |

For Females ONLY:

| | | | | | |
|---|---|---|---|---|---|
| □ | □ Birth Control Pills | □ | □ Hormonal Replacement | □ | □ Pregnancy ______weeks |
| □ | □ Heavy/painful Menstrual Cycle | □ | □ Irregular Menstrual Cycle | | |

20. Have you ever had any surgery: □ No □ Yes _______________________________________________

21. Have you ever been hospitalized? □ No □ Yes, why_____________________________________________

22. Have you had significant past trauma? □ No □ Yes

23. Indicate if you have any immediate family members with any of the following: □ Stroke □ High Blood Pressure □ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

24. Primary care doctor and phone number: ______________________________________________________

25. Please list any medications including over the counter: ____________________________________________

_____________________________________________________________________________________

26. Smoking Status (circle one): every day smoker / occasional smoker / former smoker / never smoked

27. Anything else pertinent to your visit today? __________________________________________________

Print Name: _________________________________________

Patient / Guardian Signature:______________________________ Date:________________

# Alexander Chiropractic Center

## Personal Injury Questionnaire

Name: ________________________________ Date of Accident: _______________

1. Were you the ( ) Driver or ( ) Passenger / ( ) Front Seat or ( ) Back Seat

2. Were you hit from ( ) Behind ( ) Front ( ) L Side ( ) R Side

3. Did you strike any part of your body? ( ) Yes ( ) No
   If yes, what part? ______________________________________________

4. Were you knocked unconscious? ( ) Yes ( ) No If yes explain duration: ______________________________

5. Where were you taken after the accident? ______________________________________________
   Were X-rays taken? ( ) Yes ( ) No

6. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
   If yes, please list the doctor's name and phone number: ______________________________

7. Please briefly describe the accident: ______________________________________________
   ______________________________________________
   ______________________________________________

8. Please briefly describe how you felt...a) Immediately after the accident: ______________________________
   b) Later that same day: ______________________________________________
   c) The next day: ______________________________________________

9. What are your PRESENT complaints and / or physical symptoms: ______________________________
   ______________________________________________

10. Do you have any previous illness or physical complaints that relate to this case? ( ) Yes ( ) No
    If yes, please explain: ______________________________________________

11. Did you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
    If yes, please describe: ______________________________________________

12. Have you lost time from work as a result of this accident? ( ) Yes ( ) No - If yes, last date worked: _______________

13. Since the accident occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same?

14. Have you ever been in a previous auto accident? ( ) Yes ( ) No If yes, when? ______________________________

15. Were you treated for injuries as a result of your previous accident? ( ) Yes ( ) No
    If yes, what were the results of your treatment? ______________________________

16. Do you have any continued complaints from your previous accident? ( ) Yes ( ) No
    If yes, please explain: ______________________________________________

**Please read *before* signing:**
I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I hereby authorize payment for medical benefits to **Alexander Chiropractic Center** for services rendered.

| ______________________ | ______________________ | ______________ |
|---|---|---|
| Patient Signature | Parent / Guardian Signature | Today's Date |

# Alexander Chiropractic Center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Solomons, MD 20688-1269
Phone: 410-394-1000

22930 Three Notch Rd
California, MD 20619
Phone: 301-737-4007


***PLEASE PRINT ALL INFORMATION*** ***Patient Information***

First Name: ____________________ Last Name: ___________________MI: ___ Preferred Name:________________

Date of Birth: ____/_____/____ AGE: __________ SSN: ___-__-______ ( ) Male ( ) Female

Address: ______________________________________________________________________ Apt. #: __________

City: ___________________________________________________ State: __________ Zip Code: __________

Phone Numbers: ( ) ____________________ (Home) ( ) ____________________ (Work) ( ) ____________________ (Cell)

Email address: ____________________@____________________

May we leave a voicemail regarding detailed information? Y/N May we email regarding detailed information? Y/N

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Emergency Contact: ______________________ Relationship: ___________ Contact Phone:_____________________

How were you Referred: ____________________; if by a patient what is the patient's name: ____________________

Preferred Language:___________________ Race:_____________________ Ethnicity:_______________________

**Health Insurance Information: (Please complete if you have insurance.)**

*Primary Health Insurance:*

Company: ___________________ PPO / HMO / Fed / EMO / POS Insured Name: ____________________

Relationship to patient: Self / Spouse / Child / Other ___________ Insured DOB: _____________________

Policy #: ____________________ Group #: ____________________ Insured SSN: _____________________

Claim #: ____________________ Insurance Phone: ______________ Insured Employer: ________________

*Secondary Health Insurance:*

Company: ___________________ PPO / HMO / Fed / EMO / POS Insured Name: ____________________

Relationship to patient: Self / Spouse / Child / Other ___________ Insured DOB: _____________________

Policy #: ____________________ Group #: ____________________ Insured SSN: _____________________

Claim #: ____________________ Insurance Phone: ______________ Insured Employer: ________________

**Please Read *Before* Signing – Signature on File Statement.**

I hereby give my permission to the doctor to perform such procedures and administer treatment as he may deem medically/chiropractically necessary in the diagnosis and/or treatment of my condition. I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I authorize use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize payment directly to **Alexander Chiropractic Center**. I permit a copy of this authorization to be used in place of the original. I understand that my insurance coverage is a contract between my insurance co. and myself and that **Alexander Chiropractic Center** will submit claims on my behalf but will not be responsible for filing appeals or disputing rejections. I agree with the above requirements and request that **Alexander Chiropractic Center** submit claims on my behalf. I understand that I am responsible for all charges incurred regardless of my insurance status. I understand that there will be a $50.00 fee for all returned checks. I understand there will be a $15.00 broken appointment fee if 24 hours notice is not given.

_______________________________ Patient Signature

_______________________________ Parent / Guardian Signature

_______________ Today's Date

# Alexander Chiropractic Center

## Motor Vehicle Accident Insurance Questionnaire

Name: ________________________________ Accident Date: ____________________

State accident occurred in: ________________________

1. Has the accident been reported to the police? Y / N If yes, were they at the accident scene? Y / N If yes, was anyone cited? Y / N
   If yes, whom? ( ) Myself ( ) My Driver ( ) The other driver ( ) Other ______________________________
2. Have you retained an attorney? Y / N If yes, name of your attorney: ______________________________
   Address: ______________________________ Suite #: ____________
   City: ____________________ State: __________ Zip Code: __________
   Phone #: ( ) ____________________ Fax #: ( ) ____________________
3. Have you reported the accident to any insurance company? Y / N
   If yes, which one(s)? ( ) My own ( ) My driver's ( ) The owner of the vehicle I was in
   ( ) the other driver's ( ) The owner of the other driver's vehicle
4. Were you in your own vehicle at the time of the accident? Y / N If yes, skip to Box 2.

**BOX 1 – Information about the vehicle you were in, if it was NOT your own.**

Insured's Name: ______________________________ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: ______________________________________________

Insured's Phone#: ( ) ____________________ Insurance Co Phone #: ( ) ____________________

Ins Co for the vehicle you were in: ____________________ Policy #: ____________________

Medical Adjuster's Name: ____________________ Claim #: ____________________

Medical Adjuster's Phone #: ( ) ______________________________ Ext.: __________

Insurance Billing Address: ______________________________ Attn: ______________

**BOX 2 – Your vehicle information: (Regardless if you were in someone else's vehicle at the time)**

Insured's Name: ______________________________ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: ______________________________________________

Insured's Phone#: ( ) ____________________ Insurance Co Phone #: ( ) ____________________

Ins Co for the vehicle you were in: ____________________ Policy #: ____________________

Medical Adjuster's Name: ____________________ Claim #: ____________________

Medical Adjuster's Phone #: ( ) ______________________________ Ext.: __________

Insurance Billing Address: ______________________________ Attn: ______________

**BOX 3 – Information pertaining to the person that hit you:**

Insured's Name: ______________________________ Relationship to yourself: ( ) Self ( ) Spouse ( ) Child ( ) Other

Insured's address: ______________________________________________

Insured's Phone#: ( ) ____________________ Insurance Co Phone #: ( ) ____________________

Ins Co for the vehicle you were in: ____________________ Policy #: ____________________

Medical Adjuster's Name: ____________________ Claim #: ____________________

Medical Adjuster's Phone #: ( ) ______________________________ Ext.: __________

Insurance Billing Address: ______________________________ Attn: ______________

Have you received the Personal Injury Protection forms from your insurance company? Y / N
If yes, have you returned them to the insurance company? Y / N Do you have a copy? Y / N

The information given in this questionnaire is true to the best of my knowledge.

______________________________ ______________________________ ____________________
Patient / Guardian Signature Witness Signature Today's Date

CLAIM#:______________________

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## ASSIGNMENT OF BENEFITS AND RIGHT TO SUE FOR PIP

To Whom It May Concern:

I hereby authorize and direct any insurance company with whom I may make a claim for PIP or Med-Expense benefits, and/or my attorney, to pay directly **Alexander Chiropractic Center**, (hereinafter referred to as “this health provider”), any money that is owed to this health provider for services provided to me.

In the event that any insurance company that is obligated to reimburse me for charges I incur with this health provider refuses to make such payments after demand is made by either me or this health provider, I hereby assign and transfer to this health provider any and all causes of action that I have against said insurance company, including but not limited to the right to bring a lawsuit, for the failure to pay the available PIP and/or Med-Expense benefits up to the amount of this health provider’s full bill.

I authorize this health provider to bring any such cause of action either in my name or in this health provider’s name. I further authorize this health provider to compromise, settle or otherwise resolve any such claim arising out of the insurance company’s failure to pay to this health provider the full limit of available PIP or Med-Expense benefits up to the amount to its full bill.

I understand that I remain personally responsible for the total amounts due to this health provider for its services. I understand that payment is due at the time services are rendered, and that this health provider is providing a *courtesy* to me by trying to have the bill paid through alternative sources. I agree that this document does not constitute any consideration for this health provider to await payment, and that payment may be demanded from me immediately upon the rendering of services.

I authorize this health provider to release any information pertinent to my case to any insurance company or attorney to facilitate the collection of my bill. I agree that this health provider be given Power of Attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

Patient: __________________________

Date: _________________________

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## ASSIGNMENT AND AUTHORIZATION

You are hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills, and/or records in your possession which they request in reference to any illnesses and injuries which I have suffered.

I further, irrevocably assign to you, and authorize and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all Pip, Med-Pay, or Med-Expense payments. I hereby further give a lien on my case to said doctors against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith

It is further understood that there is a Statute Of Limitations applicable to any civil claim you may bring. In view of this, I hereby agree that the Statute Of Limitations with respect to any claim for services mentioned above will not begin to run until I send you a denial, in writing, of any outstanding balance. Said written denial *must* be mailed certified mail, return receipt requested, and said return receipt will be required to show proof of the notice of this denial.

Signature: ____________________ Date: ____________________

Witness: ____________________

**THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE ATIENT WITHIN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.**

_________________________
Attorney

# Alexander Chiropractic Center

14350 Solomons Island Road, Suite 103A
Solomons, Maryland 20688-1269
Phone: 410-394-1000
Fax: 410-394-6800

22930 Three Notch Road
California, MD 20619
Phone: 301-737-4007
Fax: 301-737-4003

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## Authorization To Pay Physician

I, ______________________________, hereby authorize the ______________________________ insurance company to pay by check made out and mailed directly to:

**Alexander Chiropractic Center**
PO Box 1269
Solomons, Maryland 20688

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, the balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, I authorize you to make the check out to me and mail it as follows:

______________________________
**C/O Alexander Chiropractic Center**
PO Box 1269
Solomons, Maryland 20688

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand that ultimately I am financially responsible for all services rendered to me.

I hereby give my permission to **Alexander Chiropractic Center** to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby give my permission to **Alexander Chiropractic Center** to file formal grievances with the Maryland Insurance Commissioner when necessary on my behalf, should my insurance company deny payment of all or part of my medical bills.

______________________________
Patient / Guardian Signature

______________________________
Today's Date

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## Third Party Disclaimer

I understand that according to the coordination of benefits portion of my health insurance, there will be no "provider discount" that applies when my third party liability case is processed, through my health insurance. I understand that I am ultimately responsible for all services rendered by **Alexander Chiropractic Center**, with no regard to the practice's participation with my health insurance, in this matter.

| ____________________ | ____________________ | ____________ |
|---|---|---|
| Patient Signature | Witness Signature | Today's Date |

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received ALEXANDER CHIROPRACTIC CENTER'S Notice of Privacy Practices for protected health information.

Date: ____________________     Name of Patient:____________________________________

Print Name

____________________________________________________

Signature of Patient/Personal Representative

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