

Patient Registration Information - Medicare

Please present insurance cards to receptionist

Health Problem (briefly describe): _____

PATIENT'S PERSONAL INFORMATION

Name (as written on card): _____

Street Address: _____
Last name First name Initial Date of Birth (Apt # _____)

City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Cell phone: (_____) _____ Sex: Male Female

Would you like reminders by text message? Yes No If yes, cell phone provider: _____

Marital status: Single Married Divorced Widowed Spouse's Name: _____

E-Mail: _____

MEDICARE INFORMATION

Medicare ID Number: _____ Effective date: _____

DO YOU HAVE ADDITIONAL COVERAGE?

As of today's date, are you employed? Yes No If yes, do you have group health coverage? Yes No

Employer & Phone #: _____

As of today's date is your spouse employed? Yes No If yes, do they have group health coverage through

their employment? Yes No Spouse's Employer & Phone #: _____

SECONDARY Insurance Company's Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: ____/____/____

Relationship to Insured: Self Spouse Other Child

Insurance Id Number: _____ Group Number: _____

PATIENT'S REFERRAL INFORMATION

Referred by: _____ If referred by a friend, may we thank them? YES NO

Name(s) of other physician(s) who care for you: _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number (home): (_____) _____ Phone number (work or cell) :(_____) _____

Assignment of Benefits * Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to **Dr. Greenberg or San Diego Chiropractic** and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, reasonable attorney's fees, as well as interest of 1½% per month, an annual percentage rate of 18% on any outstanding balance over 30 days past due. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Your Signature: _____

Date: _____

NAME: _____

DATE: _____

PLEASE IDENTIFY THE SYMPTOMS YOU HAVE: Any items that don't apply should be left blank.

HEAD:

- _____ Headache
- _____ Head Feels Heavy
- _____ Sensitive to Light
- _____ Blurred / Double Vision
- _____ Loss of Smell / Taste
- _____ Loss of Balance
- _____ Loss of Hearing
- _____ Pain in Ears
- _____ Ringing / Buzzing in Ears

JAW:

- _____ Pain
- _____ Grind Teeth While Sleeping
- _____ Clicking / Popping
- _____ Fatigue With Chewing
- _____ Locking (Open / Closed)

NECK:

- _____ Neck Pain / Stiffness
- _____ Neck Pain with Movement

SHOULDERS:

- _____ Pain in Shoulder Joint (R / L)
- _____ Pain Across Top of Shoulders

ARMS & HANDS:

- _____ Pain in Upper Arm
- _____ Pain in Elbow
- _____ Pain in Forearm / Wrist
- _____ Pain in Hands / Fingers
- _____ Pins & Needles in Arms / Fingers
- _____ Numbness in Arms / Fingers
- _____ Hands Cold
- _____ Joints in Fingers Swollen / Sore
- _____ Loss of Grip Strength

MID BACK:

- _____ Mid Back Pain / Stiffness
- _____ Pain Between Shoulder Blades

CHEST:

- _____ Chest Pain
- _____ Shortness of Breath
- _____ Pain Around Ribs
- _____ Irregular Heartbeat / Palpitations

LOW BACK:

- _____ Low Back Pain / Stiffness
- _____ Tailbone Pain

HIPS, LEGS & FEET

- _____ Pain in Buttocks (R / L)
- _____ Pain in Hip Joint (R / L)
- _____ Pain Down Leg (R / L / Both)
- _____ Knee Pain
- _____ Cramps in Legs / Feet (R / L)
- _____ Pins & Needles in Feet / Toes
- _____ Pins & Needles in Legs (R / L)
- _____ Numbness of Leg (R / L)
- _____ Feet Feel Cold
- _____ Swollen Ankles / Feet (R / L)
- _____ Weak, Painful Feet (R / L)
- _____ Numbness of Toes

ABDOMEN:

- _____ Pain in Abdomen
- _____ Gas / Bloating
- _____ Constipation, Diarrhea

MENTAL:

- _____ Loss of Memory / Concentration
- _____ Disoriented
- _____ Light-Headed / Dizzy
- _____ Nausea / Vomiting
- _____ Insomnia / Sleep Disturbance
- _____ Nightmares
- _____ Irritability
- _____ Depression
- _____ Anxiety
- _____ Fatigue
- _____ Uncoordinated Arms / Legs
- _____ Falling to One Side
- _____ Numbness / One Side of Body
- _____ Speech Problems
- _____ Fear of Driving
- _____ Personality Changes

RECENT CHANGE IN:

- _____ Bladder / Urine Function
- _____ Bowel Function
- _____ Menstrual Function
- _____ Sexual Function
- _____ Weight Gain / Loss
- _____ Sleep Habits
- _____ Emotional Strain
- _____ Work Stress

Height: _____ ft . _____ in **Weight** _____

When you are finished go back over the list and circle the three (3) worst symptoms.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various mode of physical therapy and diagnostic x-rays, on me, (or on the patient named below), for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licenses Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

As: _____
Relationship or Authority of Patient's Representative

Print Patient's Name

Date Signed

Signature of Patient

Print name(s) of doctor(s) treating this patient:

Dr. Kenneth Greenberg DC

To be completed by doctor or staff
Name and address of clinic/office:

San Diego Chiropractic

8312 Lake Murray Blvd. Suite O

San Diego CA 92119

Witness to Patient's Signature:

Translated by:

Date

To be completed by patient's representative, of necessary,
e.g., if patient is a minor or physically or legally incapacitated:

Print Name of Patient

Print Name of Patient's Representative

Signature of Patient's Representative

Payment Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. 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 do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't 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.

2. Co-payments 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. We accept payment in the form of cash, check or credit card.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or considered necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid 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.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims 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 company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 30 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Interest will be accrued at a rate of 18%. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly 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.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date