132 Albany Street
Cazenovia, NY 13035

SWICK
Dr. Thomas Swick
Chiropractic
swickchiro.com

315-655-8008

Patient History

Date: _____/_____/_____

Legal Name: _____ Phone: Home: _____
Preferred Name: _____ Cell: _____
Address: _____ Preferred Contact: ❑ Home ❑ Cell ❑ Text ❑ Email
City: _____ Email: _____
State/Zip: _____ Birth Date _____ Age_____ Sex: M F
Employer_____ Social Security # _____
Occupation _____ Circle One: Married Widowed Divorced Separated Single
Name of Spouse: _____

Emergency Contact

Name of Emergency Contact: _____ Relationship to You: _____
Best Contact Phone #: _____

If Patient is a Minor:

Parent/Guardian: _____ Phone: Home: _____
Preferred Name: _____ Cell: _____
Address: _____ Preferred Contact: ❑ Home ❑ Cell ❑ Text ❑ Email
City: _____ Email: _____
Employer_____ Birth Date _____ Age_____ Sex: M F
Occupation _____ Social Security # _____

Financial Responsibility

Were you injured at work? ☐ Worker's Comp Were you injured in a car accident? ☐ No Fault

Party responsible in addition to yourself: ☐ Spouse ☐ Parent/Guardian

We are a non-participating provider. We will provide statements for you to submit claims to your insurance company as an Out-of-Network Provider. Payment is expected at the time services are rendered unless other arrangements are made ahead of time.

Will you be submitting claims to your insurance company for our services? ❑ Yes ❑ No

Medicare Patients: If Medicare (National Government Services) is your primary insurance carrier, we will submit a claim on your behalf for Medicare reimbursement consideration. Please provide your Medicare card and, if applicable, secondary insurance card for copying and complete the information below.

Medicare #: _____ Medicare Provider: _____

Secondary/Supplemental Insurance: _____

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Current Health Condition

Purpose for this appointment: _____

Whom may we thank for your referral: _____

Names of other doctor(s)/medical professional(s) seen for this condition: _____

_____

Date (s) when other professionals were seen: _____

Type of Treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? ❑ Y ❑ N

Is condition due to: ❑ Workplace Injury ❑ Auto Accident ❑ Home Injury ❑ Fall

❑ Other _____

Date of Accident: _____ Time of Accident: _____

If work related, have you reported it to your employer? ❑ Written ❑ Verbal ❑ No report

If Auto Accident related, have you made a claim to your insurance company and/or agent? ❑ Yes ❑ No

Current Medication(s): _____

Known Allergies: _____

Current Supplements/Homeopathic therapy: _____

Do you wear shoe lift(s)? ❑Yes ❑No

Do you suffer from any condition other than that which you are now consulting us? ❑ Yes *(please explain)* ❑ No

_____

_____

Past Health History

Please check and provide details: *(use back of page if necessary)*

Surgeries/Operations: _____

Accidents or Falls: _____

Hospitalizations (Other than Above): _____

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Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions MUST be answered carefully, as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Eating Disorder
- ☐ Seizure Disorder
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid Issues
- ☐ Sleep Apnea
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy Mental Disorder
- ☐ Lyme Disease
- ☐ Eczema
- ☐ Celiac
- ☐ Allergies

Do you consume:

Coffee:	☐ x/day
Tea:	☐ x/day
Alcohol:	☐ x/day
Cigarettes:	☐ x/day
White sugar:	☐ x/day
Diet soda:	☐ x/day

Have you been tested HIV positive?: Y N

Do you vape? Y N

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

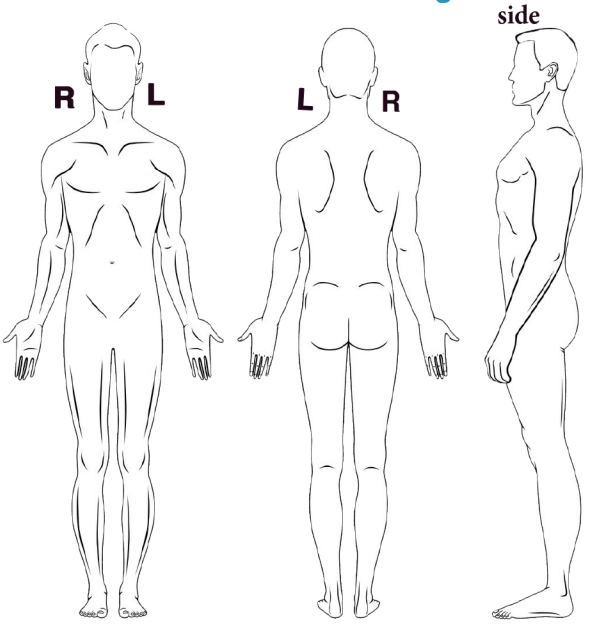
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

_____

_____

_____

Please outline your area of discomfort on the diagram:



FAMILY HISTORY

The following members of my family have same/similar symptoms as I have:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

Females Only

Date of last period:

_____

Are you pregnant?
Y N

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Payment Policy

Date:____/____/_____

I understand that...

- Payment is due when services are rendered.
- Swick Chiropractic Office is an out-of-network provider and does not participate with insurance companies except for Worker's Compensation and No Fault Claims. I will be given a receipt to submit to my insurance company for reimbursement consideration.
- Whether I submit claims or Swick Chiropractic submits claims on my behalf for WC or NF, in the event that the claim is denied, I will not hold Swick Chiropractic Office responsible.
- In the event that I have an outstanding balance due to extenuating circumstances, my account will be charged a 5% Finace Charge if my balance becomes 45 days overdue. Furthermore, in the event that my account is sent to a collections agency, I agree to pay all late charges and/or collection costs.
- If my payment becomes more than 45 days late, my care may be put on hold until payment is up to date.

Name (Please Print)*: _____

Signature*: _____

*If patient is a minor, parent or guardian who is responsible for payment *must* sign.

Credit Authorization

Our office requires that ALL patients complete the following credit card authorization.
This guarantees our payment for services rendered. Please be assured that all of your records, whether medical or financial, will be held strictly confidential.

- We would only use your credit card number in the event that your account balance becomes 45 days delinquent and you do not attempt to make satisfactory arrangements with this office.

- I authorize Swick Chiropractic Office to charge my credit card in the event that my account balance becomes 45 days delinquent.

_____ _____
Name on Card (Printed) Signature

☐ **MasterCard** ☐ **Visa** ☐ **Discover** ☐ **American Express**

Credit Card #: _____ Exp. Date: _____

CID/CVV 2 (3 digit security code on back of card): _____

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HIPAA – Patient Acknowledgement of Receipt of Notice of Our Privacy Practices

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices of Swick Chiropractic Office, LLC.

I have the right to review the Notice of Privacy Practices prior to signing this form. If I do not sign this form, Swick Chiropractic Office, LLC, may decline to provide treatment to me.

Swick Chiropractic Office, LLC, reserves the right to revise its Notice of Policy Practices at any time. A copy of such revisions is available upon written request.

_____ _____
Patient/Guardian Signature Date

_____
Print the Patient/Guardian Name

MEDICARE PATIENTS ONLY:

For patients with Medicare as their primary insurance carrier, please read and sign:

I authorize the release of any medical or other information necessary to process claims to Medicare through National Government Services (NGS) and I understand NGS will forward claims to my secondary insurance if applicable.

I understand that Medicare does not reimburse for some of the services that will be rendered including but not limited to the Initial Exam and X-ray review. Swick Chiropractic Office will submit my claims to NGS on my behalf who will forward claims to my secondary insurance, if applicable, for consideration of reimbursement. I request payment of government benefits or secondary insurance benefits to myself.

_____ _____
Patient Signature Date

_____
Print the Patient Name