Omdalen Chiropractic Clinic, P.C.

Today's Date:____________

Patient Information

First name: ______________________________ MI: _________ Last name:____________________________

Address: _______________________________________ City/State/Zip: ______________________________

Date of Birth: __________________________________ Social Security Number: _______________________

Email: ____ Gender: M / F Marital Status: M S D W

Home Phone: ___________________________________ Cell phone: ________________________________

Employer: ______________________________________ Employer Phone: ____________________________

Emergency Contact Information

Full Name: ______________________________________ Relationship: ______________________________

Phone Number(s): ____

Previous Care

Date of Last Physical Exam: _________________ Have you received any previous chiropractic care? Yes No

Other doctors seen for this condition: ____

List medications and vitamins you are taking: ____

List Surgeries, Date, Type, and Reason: ____

Major Injuries/Traumas: ____

Major Hospitalizations: ____

List relevant major health problems of immediate relatives: ____

Insurance/Financial Information

Have your card with you? We will make a copy.

Type: Cash Private Health Insurance Medicare Workman's Comp Accident ND Medicaid

Insurance Name and Address: ____

Policy Number: __________________________________ Group Number: _______________________________

Policy Holder Name (if other than self): ____

Who is responsible for payment? Self / Other (name and relationship) _________________________________

Responsible party's address (if other than self): ____

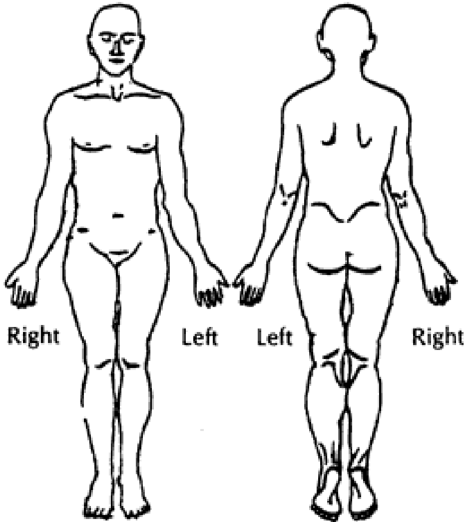
Responsible party's phone number: ____

It is policy to pay when services are rendered unless otherwise arranged.

Omdalen Chiropractic Clinic, P.C.

HEALTH QUESTIONAIRE

Please mark your areas of pain on figures below.



Describe Major Complaint(s): ________________________
____
____

When and how did it begin? ________________________
____
____

List activities that cause pain in region of complaint (i.e. walking, sitting, bending): __________________________
____

List activities that relieve pain in region of complaint (i.e. icing, stretching): ________________________________
____

Write an X for current and P for past for conditions listed below.

Musculo-Skeletal System

__ Low back problems
__ Hip problems
__Pain between shoulders
__ Sore muscles
__ Neck problems
__ Shoulder problems
__ Arm problems
__ Weak muscles
__ Leg problems
__ Ruptures
__ Swollen joints
__ Broken bones
__ Foot/Ankle problems
__ Subluxations
__ Painful joints
__ Knee problems
__ Hand/Wrist problems

Genito-Urinary System

__ Bladder trouble
__ Painful urination
__ Excessive urination
__ Bladder/Kidney infection
__ Scanty

Gastro-Intestinal System

__ Poor appetite
__ Indigestion
__ Excessive hunger
__ Abdominal pain
__ Crave sweets
__ Diarrhea
__ Difficult chewing
__ Gas
__ Difficult swallowing
__ Constipation
__ Excessive thirst
__ Bloody stools
__ Nausea
__ Hemorrhoids
__ Belching
__ Liver trouble
__ Vomiting
__ Gall bladder problems
__ Overweight
__ Underweight

Female Only

__Vaginal discharge
__ Menstrual cramps
__ Vaginal bleeding
__ Hot flashes
__ Vaginal pain
__ Irregular periods
__ Breast pain
__ Lumps on breast

Nervous System

__ Numbness/tingling
__ Headaches
__ Loss of feeling
__ Light bothers eyes
__ Fatigue
__ Muscle jerking
__ Paralysis
__ Loss of balance
__ Pins & Needles
__ Convulsions
__ Dizziness
__ Forgetfulness
__ Fainting
__ Cold hands/feet
__ Difficulty sleeping
__ Confusion
__ Irritability/tension
__ Depression

Cardio-Vascular-Respiratory

__ Chest pain
__ Blood pressure problems
__ Pain over heart
__ Heart problems
__ Difficult breathing
__ Lung problems
__ Asthma/Short of breath
__ Varicose veins
__ Persistent cough
__ Hiatal hernia
__ Coughing phlegm
__ Rapid heartbeat

Eye, Ear, Nose, & Throat

__ Eye strain
__ Sore gums
__ Eye inflammation
__ Wear dentures
__ Vision problems
__ Dental problems
__ Blurring of vision
__ Sore mouth
__ Wears glasses/contacts
__ Sore throat
__ Ear pain
__ Hoarseness
__ Ear noises
__ Difficult speech
__ Ear discharge
__ Tonsillitis
__ Hearing loss
__ Thyroid problems
__ Nose pain
__ Allergies
__ Nose bleeding
__ Sinus trouble
__ Difficulty breathing through nose

Omdalen Chiropractic Clinic, P.C.

Patient Payment Requirements

Dear Patient,

Thank you for choosing us as your health care provider. The following is a description of our financial policy:

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, and Discover. We reserve the right to collect before services are rendered.

All charges are your responsibility whether the insurance company pays or not. Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage. Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.

If coverage for a particular service and or supply is denied by your insurance company, we may require you to follow up with your insurance and/or pay the balance due. Unless you are insured by Medicare or an insurance group which our doctor is a participating member, or double- insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered. If you are a member of an HMO or Managed Care Program or have a PCP (Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your agreement with your insurance company.

We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with an Account Manager if you encounter such problems, so that we may assist you in the management of your account. You may reach an Account Manager at (701) 786-4024.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

By signing this form, I agree to the terms and conditions outlined in the financial policy stated above.

____ ______________________________

Patient's or Guardian's Signature Date

____

Patient's Name (printed)

Omdalen Chiropractic Clinic, P.C.

Receipt of Notice of Privacy Practices

Patient Name: ____

Date of Birth: ____

Date the Notice was received: ______________________________________

My signature on this form acknowledges that I have received a copy of the Omdalen Chiropractic Clinic, P.C. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Omdalen Chiropractic Clinic, P.C. and my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_________________________________ _________________________

Patient's Signature Date

____

OFFICE USE ONLY

To be completed by clinician if form is not signed

1. Was the patient provided with a copy of the Omdalen Chiropractic Clinic P.C. Notice of Privacy Practices? ___ Yes ___No
2. Briefly describe efforts made to obtain the patient's acknowledgement of receipt of the notice and explain why the patient was not able or willing to sign this form:
   ____
   ____
   ____

_________________________________ ____________________________

Signature of clinician Date