PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial

Date of Birth _____ Age _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Sex ☐Male ☐Female Marital Status ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Email _____ Primary Care Provider _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Emergency Contact _____ Phone _____ Relationship _____

Person responsible for account _____ Relationship to patient _____

Primary Insurance

Subscriber Name _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birth Date _____ Soc. Sec # _____

Address (if different from patient) _____ Phone # _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

ID # _____ Group # _____ Effective Date _____

Secondary Insurance

Subscriber Name _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birth Date _____ Soc. Sec # _____

Address (if different from patient) _____ Phone # _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

ID # _____ Group # _____ Effective Date _____

Signature _____ **Date** _____

HEALTH HISTORY

Date of Visit: ____/____/____

Name:_____ Primary Doctor:_____ DOB: ____/____/____

Pregnant ☐Yes ☐ No ☐Unknown

PAST MEDICAL HISTORY:

Please check below if you have, or have had, any of these medical conditions:

☐NO PAST MEDICAL PROBLEMS
☐Acid reflux
☐Adverse reaction to anesthesia
Type of reaction: _____
☐Alzheimer's or significant memory loss
☐Anemia
☐Angina or chest pain
☐Asthma
☐Atrial fibrillation or erratic heartbeat
☐Bladder problems
☐Bleeding ulcers
☐Blood clot
☐Legs ☐Lungs ☐Other_____
☐Cancer type:_____
☐Congestive heart failure
☐Coronary artery disease
☐Dental disease
☐Depression
☐Diabetes
☐Emphysema
☐Epilepsy/Seizures
☐Fibromyalgia
☐Gout
☐Hemophilia/Excessive Bleeding
☐Hepatitis or Liver Disease
☐High blood pressure/Hypertension
☐High cholesterol
☐HIV or Aids
☐Infections:_____
MRSA: ☐Yes ☐No
☐Kidney disease
☐Osteoarthritis
☐Osteoporosis
☐Pneumonia
☐Psychiatric Disorder
☐Rheumatoid Arthritis
☐Sickle cell
☐Sleep Apnea
☐CPAP machine
☐Stroke (CVA)
☐Thyroid disease
☐Pregnancy: Date _____
☐Other not listed, explain:
_____
_____

SURGICAL HISTORY:

Please check below if you have had any of these surgeries:

☐NO PREVIOUS SURGERY
☐Abdominal surgery
Type of surgery: _____
☐Aneurysm
☐Angioplasty/Stents
☐Artery bypass of arm or leg
☐Bone/Joint surgery
Type of surgery: _____
☐Breast surgery
Type of surgery: _____
☐Carotid surgery
☐Cervical spine surgery
☐Colon cancer
☐Coronary bypass (CABG)
☐Heart valve replacement
☐Hysterectomy: Date _____
☐Lumbar spine surgery
☐Pacemaker/Defibrillator
☐Prostate surgery
☐Other not listed, explain:
_____

FAMILY HISTORY:

Please check below if any of your immediate relatives have had any of the following and list whom beside the condition:

☐NO FAMILY MEDICAL HISTORY TO REPORT
☐Cancer _____
☐Adverse reaction to anesthesia_____
☐Bleeding disorders_____
☐Blood clots/Pulmonary embolism
_____
ADOPTED ☐Yes ☐No
☐Hypertension_____
☐Depression_____
☐Diabetes_____
☐Heart disease _____
☐Other not listed, explain:
_____
☐Stroke _____
☐Osteoarthritis_____
☐Osteoporosis_____

Patient Name:_____ DOB: ____/____/____ Date of visit: ____/____/____

SOCIAL HISTORY:

Marital Status ☐Single ☐Married ☐Partner ☐Divorced ☐Widow/Widower

Hobbies_____

Smoking: ☐Never smoked ☐Former smoker ☐Current smoker How many packs/day? _____

Do you dip or chew tobacco? ☐Yes ☐No If yes, how much per day? _____

Do you drink alcoholic beverages? ☐Yes ☐No If yes, how many drinks per week? _____

Do you use recreational drugs? ☐Yes ☐No If yes, what and how often? _____

REVIEW OF SYSTEMS

Please check below if you have, or recently experienced, any of these medical conditions:

Leg Swelling	☐	Skin wounds/rash	☐	Seizures	☐
Weight gain/loss	☐	Shortness of breath	☐	Psychological problems	☐
Fever/Chills/Night sweats	☐	Abdominal pain	☐	Depression	☐
Fatigue	☐	Black/tarry stools	☐	Anxiety	☐
Vision problems	☐	Arm/leg pain	☐	Easy bleeding/bruising	☐
Dental problems	☐	Urinating at night	☐	Swollen glands	☐
Chest pain	☐	Incontinence	☐	Irregular heartbeat	☐
Impotence	☐	Palpitations	☐	Gynecological problems	☐

LIST ALL KNOWN ALLERGIES TO MEDICATIONS

☐NO KNOWN MEDICATION ALLERGIES

1._____ Reaction type:_____

2._____ Reaction type:_____

3._____ Reaction type:_____

Are you allergic to Latex? ☐Yes ☐No

Are you allergic to tape? ☐Yes ☐No

CURRENT MEDICATION

Please include herbal and over-the-counter drugs. List all medications with dosage. Use additional sheet if needed.

☐NOT CURRENTLY TAKING MEDICATION

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

Other Payment Sources

Is patient seeking treatment for injuries sustained in an accident? ☐ Yes ☐ No

If yes, please provide the following information:

Date of Accident _____

Name and Address of Attorney, if any _____

_____

Name and Address of Responsible Party, if any _____

_____

Name and Address of Responsible Party's Insurance Company, if any _____

_____

PATIENT CONSENT AND FINANCIAL RESPONSIBILITY

THE FOLLOWING TERMS, CONDITIONS AND POLICIES ARE IMPORTANT AND WILL GOVERN YOUR RELATIONSHIP WITH AND LEGAL OBLIGATIONS TO MULTI-CARE SPECIALISTS, S.C. ("MULTICARE") AND ITS HEALTHCARE PROVIDERS, INCLUDING ASHLEY EAVENSON D.C.; JONATHON BROOKS D.C.; MARK EAVENSON D.C.; DAVID PRIEBE M.D.; JOSH WIDEMAN D.C.; COREY VOSS P.T.; and GEOFFREY MILLER P.T.A. ("PROVIDERS"). YOU SHOULD READ THIS DOCUMENT CAREFULLY BEFORE SIGNING.

Consent to Treatment

Multi-Care and Providers are hereby authorized to provide treatment and health care services to patient.

Payment

Payment, including co-payments and deductibles if applicable, is due on each date of service for the services rendered on that date, unless other arrangements have been made in writing. Unless otherwise agreed in writing, Multi-care is entitled to receive the standard rates set forth from time to time in its published fee schedule for the services provided to patient, plus all out of pocket expenses reasonably incurred for patient's care. Multi-care is entitled to receive the reasonable value of any services provided to patient that are not specifically listed in Multi-Care's published fee schedule.

*24-hour notice of appointment cancellation is required. A cancellation fee of **$75.00** is payable for any missed or cancelled appointment if timely notice of cancellation has not been given. Health insurance and other health care benefit plans do not typically pay fees for late cancellations or missed appointments.* _____ **(Please initial)**

If payment is not made when due, Multi-Care will be entitled to recover all costs of collection incurred, including reasonable attorney fees.

Assignment of Benefits

If patient or patient's representative is entitled reimbursement or payment of amounts payable to Multicare Specialists or Providers by an insurance carrier, benefit plan or other third party payer ("Payment Sources"), Multicare Specialists is authorized to submit claims to Payment Sources on behalf of patient or patient's representative. However, except as otherwise required by law, Multicare Specialists may, in its sole discretion, elect (a) not to submit claims for all or any part of its services, (b) not to submit claims to one or more Payment Sources, and (c) accept payment from any one or more of Payment Sources, without waiver or reduction of any right or claim to payment from patient or patient's representative or from any other source. Except to the extent otherwise allowed by law, patient (or, if applicable, patient's representative) shall remain primarily responsible for payment even if Multicare Specialists fails to submit claims to one or more potential Payment Sources or if Multicare Specialists is not paid in full by the Payment Sources to which claims are submitted.

To the fullest extent allowed by law, patient (or, if applicable, patient's representative) hereby assigns to Multicare Specialists any and all rights to payment from any one or more of Payment Sources for healthcare services now or hereafter provided to patient by Multicare Specialists or Providers, including (without limitation): (a) amounts payable under any private or public insurance or other benefit plan, including any group or individual accident, disability or health insurance policy or benefit plan or any automobile insurance policy; (b)compensation payable for such services under worker's compensation, occupational disease or other comparable laws; and (c) all proceeds of any claim or cause of action for personal injuries giving rise to such services.

Emergency

If patient has a medical emergency, patient (or patient's representative, if applicable) should contact Multicare Specialists, but if unable to reach a Provider, should call 911 or go to the nearest emergency room.

Representative

If this document is signed by a representative, the representative represents and warrants that he has legal authority to do so. If patient is a minor or has been adjudicated as a disabled adult, the patient's parent (s) or guardian (s) assumes personal responsibility.

I, _____ have read the above financial policy and understand my financial
(Print Patient's Name)

responsibility to Multicare Specialists.

_____ Dated _____
Patient Signature (or Authorized Personal Representative)

If signed by a Representative, check applicable box and attach evidence of authorization:

☐ Parent ☐ Representative of Deceased's Estate

☐Guardian ☐ Power of Attorney

A new standard of care

Jonathon D. Brooks, D.C. CHIROPRACTOR
Ashley L. Eavenson, D.C. CHIROPRACTOR
Mark J. Eavenson, D.C. CHIROPRACTOR
Joshua D. Wideman, D.C. CHIROPRACTOR
David L. Priebe, M.D. FAMILY PRACTICE
Corey W. Voss, P.T. PHYSICAL THERAPIST

multicare.. specialists

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ **Date of Birth:** _____

Person releasing records and relationship circle one: SELF OTHER:_____

By signing this form, I authorize you to obtain confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below. This is not for us to release records.

Release my protected health information to the person(s)/entity:

Name: Multicare Specialists
Street: 3986 Maryville Rd.
City: Granite City **State:** IL **Zip:** 62040

_____ _____
Patient Signature (or parent, guardian, or legal representative) **Date**