

Ravenswood Chiropractic and Wellness Center

DR TODD C RENN, P.C.

Patient Initials: _____

#: _____

WHAT TO EXPECT.....

Paperwork & Consultation...to help us get to know you, your lifestyle and health history to customize a care plan that is a solution to fit your life, health, financial, personal needs and wants.

Examination...is focused on identifying the CAUSE of the problem & how they influence your function, adaptability, health and lifestyle.

Solutions...We'll review your findings and present options for your care.

Date ____ / ____ / ____

CONFIDENTIAL PATIENT INFORMATION

Full Name _____ Social Security#: _____ - _____ - _____

Date of Birth: ____ / ____ / ____ Age ____ Sex: M F

Address _____ Apt.# ____ City _____ Zip _____

Home # (____) _____ - _____ Email _____

Work # (____) _____ - _____ @ _____ . _____

Cell # (____) _____ - _____ Occupation _____

Single Divorced Widowed Employer _____

Married → Name of Spouse / Partner: _____ Employer: _____

In Case of Emergency, please contact: _____ Phone (____) _____ - _____

How did you hear about us? Walk by Did you view our Website? Y N Physician _____

Internet Search → Google Bing Yahoo MSN Other search _____

AD in _____ Coupon for _____ Other _____

Friend Family Member Coworker → Who may we thank for referring you? _____

May the doctor speak orally or in writing to your health care provider or person who referred you regarding your case? Yes No Reason for Today's Visit _____

****Please submit a copy of your: drivers license (or ID), insurance card(s), additional documents or any medical reports or imaging films that you may have.**

Paperwork...Insurance claims are gladly filed by our office.

We...accept Cash, Check & Credit Card as forms of payment for any balances that may exist.

Solutions... We have numerous policies so that we can work with everyone's finances to accommodate your health care needs.

Please indicate below which category your financial situation applies.

Health Insurance

Policy Holder (if other than self): Spouse / Partner / Parent Name: _____

DOB: ____ / ____ / ____ SS # _____ - _____ - _____

Medicare OR **Medicare with Supplemental Insurance**

Self Pay

Pay at the time of service (TOS) and receive a 35% discount off our services.

Take advantage of one of our pre-payment all inclusive visit package programs.

Accident Information Is condition due to an accident? No Yes, Date ____ / ____ / ____

Auto Accident/Private Insurance (Additional Information is needed)

Worker's Compensation (Additional Information is needed)

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PURPOSE FOR YOUR VISIT...

PRIMARY COMPLAINT (List only one): _____

How & When did you first experience this problem? _____

Please describe the location of the pain: _____

Does this problem cause the pain to travel to any other area? No Yes, where? _____

How often do you experience this problem? daily/constant _____ times per week

Is this problem getting: worse? better? staying the same?

Does it interfere with your: Work Sleep Daily Routine Recreation Other _____

Activities, movements that is painful to perform: Sitting Standing Walking Bending

Lying Down Other _____

Have you seen any other doctors for this problem? No Yes, who? _____

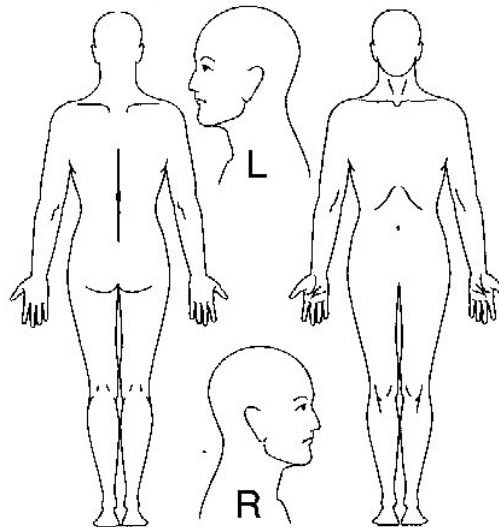
What treatment was given? _____ How effective was the care? _____

What else have you tried to relieve this problem (treatments, aspirin, medications, surgery)? _____

Type of pain: Sharp Shooting Burning Throbbing Dull Aching Cramps Stiffness

Swelling Numbness Tingling Other _____

Please indicate where the pain is occurring by drawing on the pictures to the right. →



Please circle the number which best describes your pain for each question below. ↓

Pain right Now	0	1	2	3	4	5	6	7	8	9	10
Pain at Best	0	1	2	3	4	5	6	7	8	9	10
Pain at Worst	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

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SECONDARY COMPLAINT (List only one): _____

How & When did you first experience this problem? _____

Please describe the location of the pain: _____

Does this problem cause the pain to travel to any other area? No Yes, where? _____

How often do you experience this problem? daily/constant _____ times per week

Is this problem getting: worse? better? staying the same?

Does it interfere with your: Work Sleep Daily Routine Recreation Other _____

Activities, movements that is painful to perform: Sitting Standing Walking Bending

Lying Down Other _____

Have you seen any other doctors for this problem? No Yes, who? _____

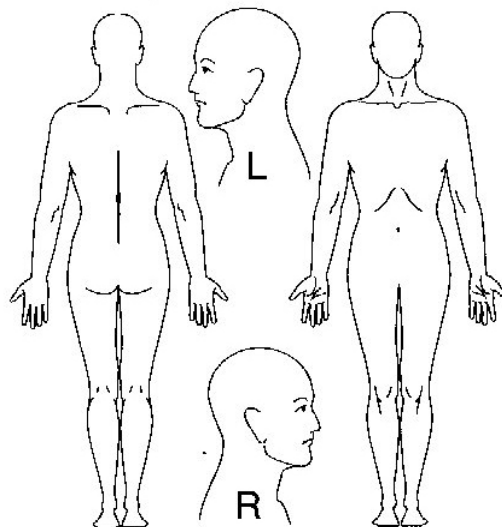
What treatment was given? _____ How effective was the care? _____

What else have you tried to relieve this problem (treatments, aspirin, medications, surgery)? _____

Type of pain: Sharp Shooting Burning Throbbing Dull Aching Cramps Stiffness

Swelling Numbness Tingling Other _____

Please indicate where the pain is occurring by drawing on the pictures to the right. →



Please circle the number which best describes your pain for each question below. ↓

Pain right Now	0	1	2	3	4	5	6	7	8	9	10
Pain at Best	0	1	2	3	4	5	6	7	8	9	10
Pain at Worst	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

HEALTH HISTORY

Place an (X) in any box to indicate if you currently or have had in the past year any of the following:

- | | | |
|----------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Gout | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pinched Nerve | |

INJURIES/SURGERIES you have had:

Head Injuries _____ /_____/_____ Surgery _____ /_____/_____
 Broken Bones _____ /_____/_____ Surgery _____ /_____/_____
 Dislocations _____ /_____/_____ Falls _____ /_____/_____

CURRENT LIFESTYLE HABITS:

Exercise: Frequency: None _____ days/wk Duration: _____ min per day
 Type: Walking Running/Jogging Weight Lifting Swimming Biking Yoga/Pilates Other _____
Work: Usual Activity: Sitting Standing Walking _____
 Type: Light Labor Medium Heavy Labor _____
Habits: Smoking: Packs/Day _____ Years _____ Alcohol: Drinks/Week _____
Coffee/Caffeine Drinks: Cups/Day _____ High Stress Level: Reason: _____

Medications	Reason For Taking	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HEALTH HISTORY: Significant Illnesses

Condition	Father	Mother	Sister	Brother		
Age:						
1						
2						
3						
4						
5						

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system and spine that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

About Your Care

There are three phases of care that Chiropractic patients often go through. **The first...** is Initial Intensive Care which corrects the most recent layer of Spinal and Neurological damage (VSC Vertebral Subluxation Complex). This care often reduces or eliminates the symptoms. **Then...** begins Reconstructive Care which corrects the years of damage that occurred when there were few symptoms. And **Finally...** Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your goals.

Acknowledgements, Policies & Agreements

HIPAA Acknowledgement _____ *initials*

I acknowledge that I have received a copy of Ravenswood Chiropractic & Wellness Center's (DR TODD C RENN, P.C.) Practice's Privacy Notice that has an effective date of March 1, 2006.

Payment Expectation Policy _____ *initials*

For insurance patients it is your responsibility to pay for any co-payments, deductibles, and co-insurance required by your insurance plan, as well as all services provided and not covered by your insurance plan (patient insurance portions). We are happy to provide any service(s) you need, however, if your insurance plan does not cover certain services, you will be responsible for payment. If we have not received payment from your insurance plan within 60 days after the date of service, or if the insurance plan has denied payment in part or in full, we reserve the right to defer the outstanding balance to you.

The above mentioned patient insurance portions and any self pay payments are expected at the time of service, as well as any prior balance you might owe. If balance cannot be paid in full,

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other arrangements need to be made prior to service. We accept Cash, Check, Credit Card (Visa, MasterCard & Discover) in satisfaction of your obligation. We will bill outstanding balances to you monthly and payment is due upon receipt. Unpaid balances that are owed for more than 30 days will accrue at an interest rate of one and a half (1.5) percent per month.

I understand this policy has no expiration date. I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits that is applicable and otherwise payable to me. I authorize DR. TODD C. RENN, P.C. and its agents to submit all health insurance claims, for services rendered, to my insurance company. If for any reason my insurance company denies/rejects my claim I am fully responsible for the balance on the account. I authorize DR. TODD C. RENN, P.C. and its agents to release information from my medical chart that pertains to filing and providing adequate documentation for any insurance claim. I agree to pay any and all collection costs, attorney fees, and/or court costs, should they arise; from an attempt to collect a debt. I hereby authorize DR. TODD C. RENN, P.C. (or a contracted 3rd party agent) to submit any and all credit discrepancies to any credit-reporting bureau and/or run a credit inquiry now or at any time I may owe money.

MISSED APPOINTMENTS _____ *initials*

Every appointment is important. The practitioner has set aside that time to meet with you. If you cannot make a scheduled appointment, kindly call the office and give 24 hours notice. If you do not give 24 hours notice, we reserve the right to apply an administrative cancellation fee to your account for the following types of appointments:

\$30 for Chiropractic

\$45 for Massage

\$60 for Acupuncture

PRINTED Name of Patient: _____

X _____ & Date: ____/____/____

Signature of Patient (or Guardian/Guarantor; or if Patient is a Minor)

PRINTED Name of Guardian/Guarantor: _____

Consent For "Evaluation of Minor"

I, _____ being the parent or legal guardian, hereby authorize DR TODD C. RENN, P.C. to examine _____.

(Name of Minor)

Other Notes: