RAVENSWOOD CHIROPRACTIC & WELLNESS CENTER

5215 N Ravenswood, Suite 105 ● 773.878.7330 ● RennWellness.com

DR TODD C RENN, P.C.

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#: _____ - _____ - _____

Preferred Name: _____ Date of Birth: ____/ _____/ _____ Age_____ Sex: M F

Address_____ Apt.# _____ City _____ Zip _____

Email:_____@ _____ . _____

Cell # (_____) _____-_____ Home # (_____) _____-_____

Marital Status: Single Other Married → Name of Spouse / Partner: _____

Cell # (_____) _____-_____ Work # (_____) _____-_____

Employment Status: P/T Student F/T Student Employed → Name: _____

Address_____ City _____ Zip _____

Work # (_____) _____-_____ Occupation _____

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

How did you hear about us? ☐ Walk by ☐ AD in_____ ☐ Coupon for_____

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

☐ Internet Search: _____ ☐ Online Directory:_____ ☐ Did you view our Website? Y N

☐ Other_____

☐ Practitioner/ Physician: _____ Phone #: (_____) _____-_____

May we inform your doctor of your condition, treatment & progress: YES NO

Dr. Todd C. Renn has an ownership interest in Ravenswood Chiropractic, Inc

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**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 Checks & Credit Cards as forms of payment for any balances that may exist.

Solutions... We have numerous financial programs so that we can work with everyone 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 Only** OR ☐ **Medicare WITH Supplemental Insurance**

☐ **Self Pay**

Find out how to save 33% off our services!

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)

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular: No _____

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary: No _____

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic: No _____

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic: No _____

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory: No _____

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No _____

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes: No _____

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No _____

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric: No _____

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional: No _____

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic: No _____

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal: No _____

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No _____

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine: No _____

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

Medical History:

❑Arthritis	❑Cancer	❑Diabetes	❑Heart Disease
❑Hypertension	❑Psychiatric Illness	❑Skin Disorder	❑Stroke

Surgeries:

❑Appendectomy	❑Joint replacement	❑	❑
❑Cardiovascular	❑Spinal	❑	❑

Allergies:

❑Eggs	❑Fish and Shellfish	❑Dairy	❑
❑Soy	❑Peanut	❑Wheat/Gluten	❑

Social History:

❑Caffeine used occasional	❑Caffeine used often	❑Chew tobacco occasiona	❑Chew tobacco often
❑Drink alcohol occasional	❑Drink alcohol often	❑Exercise not at all	❑Exercise occasionally
❑Exercise often	❑Experience stress occasi	❑Experience stress often	
❑Smokes cigarettes: _____ packs per day		❑Smokes cigars or pipe	

Family History:

❑Arthritis (parent)	❑Arthritis (sibling)	❑Cancer (parent)	❑Cancer (sibling)
❑Cholesterol (parent)	❑Cholesterol (sibling)	❑Diabetes (parent)	❑Diabetes (sibling)
❑Heart problems (parent)	❑Heart problems (sibling)	❑High blood pressure (par	❑ High blood pressure (sibling)
❑Psychiatric (parent)	❑Psychiatric (sibling)	❑Stroke (parent)	❑Stroke (sibling)
❑Thyroid (parent)	❑Thyroid (sibling)		

Substance Use:

❑Alcohol (past)	❑Alcohol (present)	❑Amphetamines (past)	❑Amphetamines (present)
❑Barbiturates (past)	❑Barbiturates (present)	❑Cocaine (past)	❑Cocaine (present)
❑Crystal Meth (past)	❑Crystal Meth (present)	❑Heroin (past)	❑Heroin (Present)
❑Marijuana (past)	❑Marijuana (present)		

Male Children:

❑Under 6 years	❑Under 10 years	❑Under 19 years

Female Children:

❑Under 6 years	❑Under 10 years	❑Under 19 years

Occupational Activities:

❑Administration	❑Business owner	❑Clerical/secretarial	❑Computer user
❑Construction	❑Daycare/childcare	❑Executive/legal	❑Food service industry
❑Health care	❑Heavy equipment operat	❑Heavy manual labor	❑Home services
❑Household	❑Light manual labor	❑Manufacturing	❑Medium manual labor

Is there anything else you would like to tell us about your medical history:

_____

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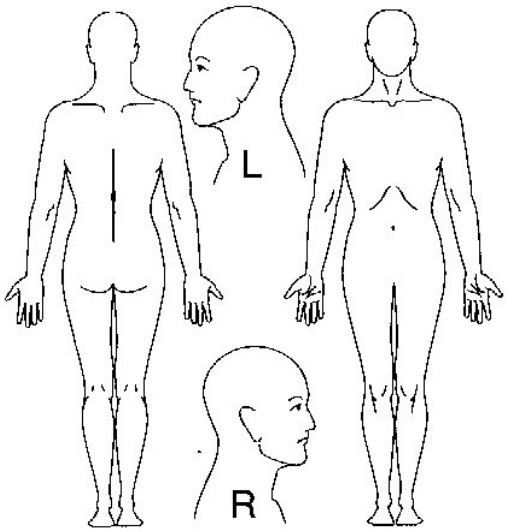
PURPOSE FOR YOUR VISIT…

PRIMARY COMPLAINT (List only one): _____

Please identify where you are having symptoms



Describe your symptoms/condition:

_____
_____
_____
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_____
_____
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_____
_____
_____
_____
_____
_____

When did your symptoms start? **Month**_____ **Day**_____ **Year**_____

How did your symptoms begin?_____

_____

Describe the nature of your symptoms.

❑ Sharp ❑ Dull ache ❑ Numb ❑ Shooting
❑ Burning ❑ Tingling ❑ Stabbing ❑ Other _____

During the past 4 weeks, indicate the average intensity of your symptoms:

0 = None to 10 = Unbearable _____/10

During the past 4 weeks, how much has it interfered with your normal routine (including both work & home):

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time ❑ None of the time

Who have you seen for your symptoms:

❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other_____

What treatment did you receive for your symptoms? When? _____

❑ Chiropractic ❑ Physical Therapy ❑ Medication ❑ Surgery ❑ Other _____

What tests have you had for your symptoms?

❑ X-rays _____M/_____YR ❑ MRI _____M/_____YR ❑ Other_____: _____M/_____YR

Have you had similar symptoms in the past? ❑ Yes ❑ No

If you have had treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other_____

In general, would you say your overall health right now is….

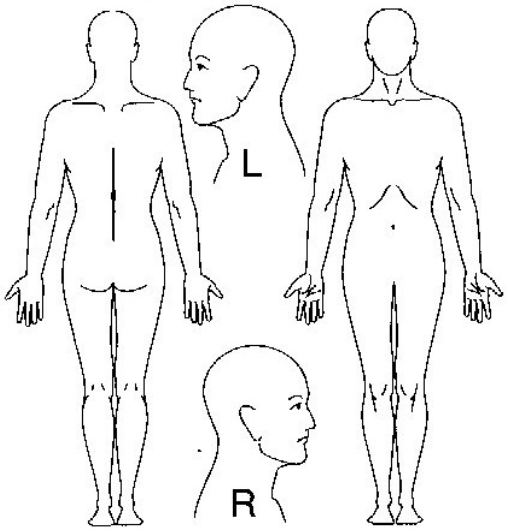
❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

Is there anything else you would like to tell us about your Primary Complaint?:

_____
_____
_____
_____
_____

SECONDARY COMPLAINT (List only one): _____

Please identify where you are having symptoms



Describe your symptoms/condition:

_____
_____
_____
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_____

When did your symptoms start? **Month**_____ **Day**_____ **Year**_____

How did your symptoms begin?_____

_____

Describe the nature of your symptoms.

❑ Sharp ❑ Dull ache ❑ Numb ❑ Shooting
❑ Burning ❑ Tingling ❑ Stabbing ❑ Other _____

During the past 4 weeks, indicate the average intensity of your symptoms:

0 = None to 10 = Unbearable _____/10

During the past 4 weeks, how much has it interfered with your normal routine (including both work & home):

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time ❑ None of the time

Who have you seen for your symptoms:

❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other_____

What treatment did you receive for your symptoms? When? _____

❑ Chiropractic ❑ Physical Therapy ❑ Medication ❑ Surgery ❑ Other _____

What tests have you had for your symptoms?

❑ X-rays _____M/_____YR ❑ MRI _____M/_____YR ❑ Other_____: _____M/_____YR

Have you had similar symptoms in the same area in the past? ❑ Yes ❑ No

If you have had treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other_____

In general, would you say your overall health right now is….

❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

Is there anything else you would like to tell us about your Secondary Complaint?:

_____
_____
_____
_____
_____

Acknowledgements, Policies & Agreements

HIPAA Acknowledgement

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 September 23, 2013.

Payment Expectation Policy

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, 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 or collection of a debt. I agree to pay any and all collection costs (35%), 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 or Cancelled Appointments

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 - you may leave a message on our voice mail if you are calling after hours. If you do not give 24 hours notice, we reserve the right to apply a $35 administrative cancellation fee for MASSAGE or ACUPUNTURE appointments to your account. There is no charge for chiropractic appointments. I understand that I am responsible for payment of this fee and it is not covered by insurance.

Voluntary Consent

I hereby attest that I am here under my own free will and understand participation in care is voluntary.

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)