

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

****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:

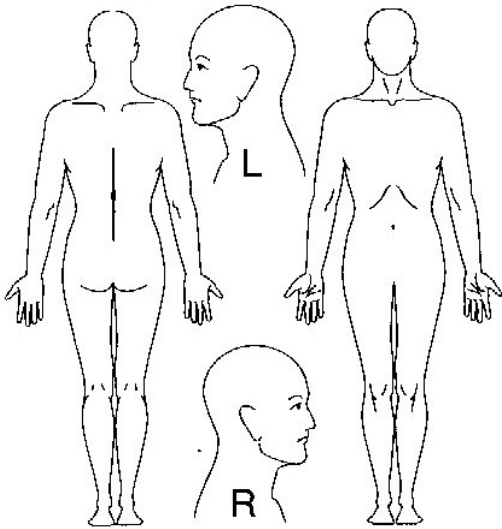
	No _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal Problems			
Menstrual Problems			

PURPOSE FOR YOUR VISIT...

PRIMARY COMPLAINT (List only one): _____

Please identify where you are having symptoms

Describe your symptoms/condition:



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 _____

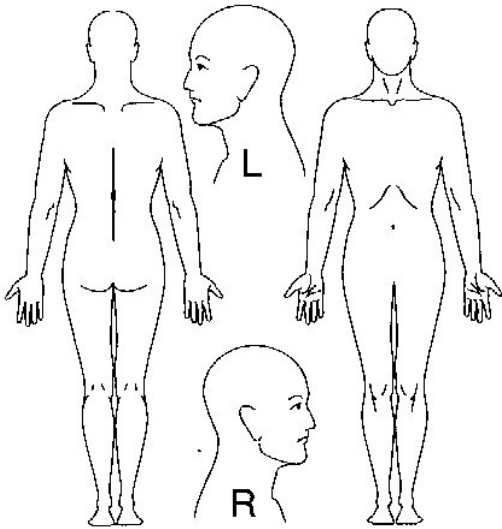
In general, would you say your overall health right now is....

- 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:



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 ACUPUNCTURE 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)