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, health and lifestyle.
Solutions...We'll review your findings and present a treatment plan & 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 # (______) ______-________ Work # (______) ______-________
Marital Status: Single Other Married → Name of Spouse / Partner: _________________________________
Spouse / Partner's Cell #: (______) ______-________
Employment Status: F/T P/T Retired Student Homemaker Unemployed Disabled (Partial / Full)
Employer's Name: ____
Address____ City _________________ Zip _________
Occupation ____
In Case of Emergency, please contact: __________________________ Phone (_____) _____-________

How did you initially hear about us?
☐ Walk by ☐ Ins Directory ☐ RennWellness website ☐ Yelp ☐ Facebook ☐ Other website directory ____________________
☐ Practitioner/ Physician → Who may we thank for referring you?____
☐ Friend ☐ Family Member ☐ Coworker → Who may we thank for referring you?_________________________________
☐ Event ____________________ ☐ Lecture ____________________ ☐ Business or Groups ____________________
☐ Other (please specify) ____

Do you want us to inform your primary care physician of your condition, treatment & progress: YES NO
Practitioner/ Physician's Name: ___________________ Phone #: (______) ______-________
Address_______________________________________ Apt.# ______ City _____________ Zip _____________

Dr. Todd C. Renn has an ownership interest in Ravenswood Chiropractic & Wellness Center

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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 assignment & 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 and 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** OR ☐ **Medicare Advantage**

☐ **Self Pay-**find out how to save 35% off our regular fees!

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:

	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			
Other			

Genitourinary:

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

Hematologic/lymphatic:

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

Neurologic:

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

Respiratory:

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

Ears/Nose/Throat:

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

Eyes:

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			
Other			

Integumentary:

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			
Other			

Psychiatric:

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			
Brain Fog			
Other__________			

Constitutional:

	Present	Past	No
Weight Loss			
Weight Gain			
Low Energy/Fatigue			
Difficulty Sleeping			

Allergic/Immunologic:

	Present	Past	No
Allergies, Food Allergies, Environmental			
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			
Other			

Gastrointestinal:

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

Musculoskeletal:

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

Endocrine:

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			
Erectile Dysfunction			
Other			

Cancer:

Date	Type

SURGERIES (Area & month/year):

❑____________________	❑____________________	❑____________________	❑____________________

MEDICATIONS:

❑____________________	❑____________________	❑____________________	❑____________________
❑____________________	❑____________________	❑____________________	❑____________________

ACCIDENTS or TRAUMA:

❑____________________	❑____________________	❑____________________	❑____________________
❑____________________	❑____________________	❑____________________	❑____________________

FAMILY HISTORY:

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

SOCIAL HISTORY:

❑Caffeine used occasional	❑Caffeine used often	❑Chew tobacco occasiona	❑Chew tobacco often
❑Drink alcohol occasional	❑Drink alcohol often	❑Experience stress occasio	❑Experience stress often
❑Smoke _______ packs per day		❑Smokes cigars or pipe	❑Uses e-cigarette

SUBSTANCE USE:

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

CHILDREN:

❑Under 5 years_____	❑Between 5-17 years____	❑18 & over______	

EXERCISE:

❑Exercise not at all	❑Exercise occasionally	❑Exercise often	❑Play sport:___________
❑Aerobic	❑Strength Training	❑Stretching	❑Yoga / Pilates

DIET & NUTRITION:

❑Supplements: Y / N	❑Eat too: much / little	❑Meals per day_______	❑Diet name: ___________
❑Diet unrestricted	❑Binge or Purge	❑Balanced	❑
❑Diet restricted	❑Food Allergies / Restrictions______________________________		

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

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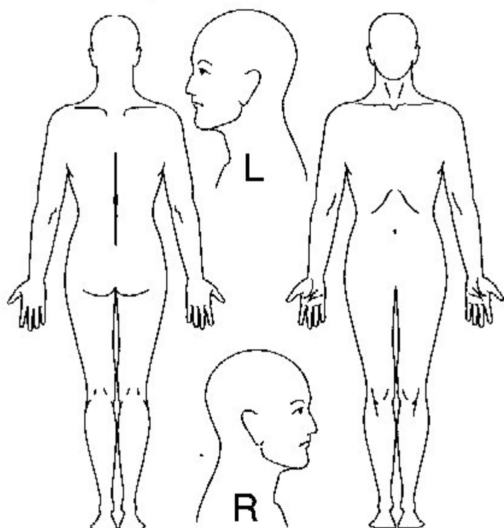
PURPOSE FOR YOUR VISIT…

PRIMARY COMPLAINT (List only one): ____

Please identify where you are having symptoms



Describe your symptoms/condition:

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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?:

____
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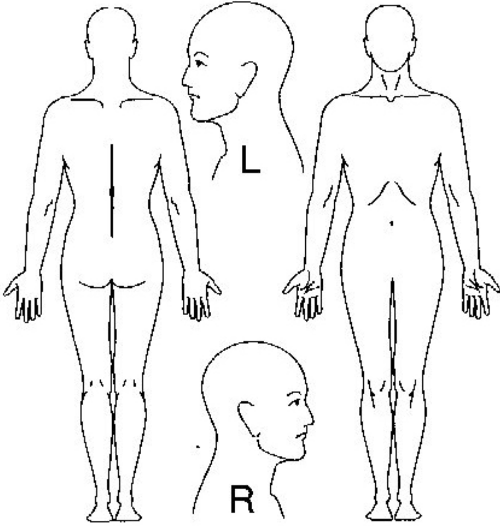
____

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?____

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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?:

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Acknowledgements, Policies & Agreements

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.

Please indicate if you would like someone other than yourself to access your account for billing and payment purposes: Name: ________________________________Relationship:_____________________

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.

Third Parties

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

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"

This office observes all laws regarding a minor patient's right to consent to, and to confidentiality of, his or her health care treatment. In addition, this office follows a policy of transitioning adolescent patients to self-management of their own health. We view our office visits as an opportunity for your child to learn to take responsibility for their health care. Therefore, as appropriate by age and maturity of the patient, parents may be asked to excuse themselves for a portion of or the entire health care visit. By signing this form, the parent or responsible party acknowledges understanding of and consent to this policy

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

(Name of Minor)