DAVIS CHIROPRACTIC

Dr. John C. Davis
Dr. Harold L. Adkins
20461 DuPont Blvd • Ste. 1 • Georgetown DE 19947
(302) 856-2225 / Fax: (302) 856-6618

Patient Information

Last Name _____ First Name _____ Middle _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) ____-_____ Work Phone (____) ____-_____ Cell Phone (____) ____-_____
Primary phone (____) ____-_____ Email _____
Occupation _____ Marital Status _____
Birth date _____ SS# _____ Sex: ☐Male ☐ Female
Patient Employer / School _____ Phone (____) ____-_____
Employer Address _____
Primary Care Physician _____ Office Phone (____) ____-_____
SPOUSE / PARENT / OTHER: Name _____ Birth date _____
Home Phone (____) ____- Work Phone (____) ____- Cell Phone (____) ____-

Insurance Information

Policy Holder Name: _____ Relationship to Patient _____
Insurance Company _____ ID # _____ Group # _____
Policy Holder Address: _____ City _____ State _____ Zip _____
Policy Holder Birth date ____/____/____ Policy Holder SS# ____-____-____
Is patient covered by additional insurance? ☐ No ☐ Yes
If Yes, Insurance Company _____ ID # _____ Group # _____
***Dr. John Davis is a participating provider with Blue Cross Blue Shield and Medicare. All other insurance companies may have out of network benefits, but there is no guarantee. _____ (Patient Initials)**

Assignment and Release

I certify that I, and /or my dependent(s), have insurance coverage with the above company(ies), and assign directly to ***Dr. John Davis*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for related services. This consent will only be terminated upon written request.

Patient/Parent/Guardian/Personal Representative *Signature* _____

Patient/Parent/Guardian/Personal Representative *Printed Name* _____

Date ____/____/____ Relationship to Patient _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (Patient Name), acknowledge that I have been advised of the Notice of Privacy Practices of Davis Chiropractic, Inc. I would like to receive a copy of this notice (please circle one): YES or NO

Patient/Parent/Guardian/Personal Representative Signature _____

Relationship to Patient ☐ Self ☐ Other _____

PATIENT NAME _____

Accident Information

DATE _____

Is condition due to an accident? ☐ No ☐ Yes

Date of Accident: ____/____/____

Type of accident? ☐ Auto ☐ Work ☐ Home ☐ Other

To whom has the accident been reported to?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

Office Use Only:

Height_____

Weight_____

BP_____ L or R

Heart _____ 02% _____

Patient Condition

AREA OF COMPLAINT #1 _____ **(mark figure below)**

When Did It Start_____ ☐ Not sure when it started ☐ Experienced this before

How Did It Start _____

Side of pain:	☐ Left	☐ Right	☐ Both	☐ Center	☐ None	
Intensity:	☐ Minimum	☐ Mild	☐ Moderate	☐ Severe	☐ Unbearable	☐ None
What Does	☐ Burning	☐ Dull Ache	☐ Numb	☐ Sharp	☐ Shooting	
It Feel Like:	☐ Stabbing Pain	☐ Tightness	☐ Tingling	☐ Throbbing	☐ Radiating Pain, show where on chart	
Makes Pain	☐ Acupuncture	☐ Chiropractic Therapy	☐ Heat	☐ Ice	☐ Muscle Relaxer	
Better:	☐ Massage Therapy	☐ Nothing Works	☐ Pain Medicines		☐ Physical Therapy	
	☐ Sleep/Rest	☐ Stretching	☐ Therapy		☐ Other_____	
Frequency:	☐ Constantly (76-100% of Day)	☐ Frequently (51-75% of Day)	☐ Occasionally (26-50% of Day)			
	☐ Intermittently (0-25% of Day)	☐ None				
	☐ 1-3 Days per Week	☐ 4-7 Days per Week	☐ ____ Days per Month			

AREA OF COMPLAINT #2 _____ **(mark figure below)**

When Did It Start_____ ☐ Not sure when it started ☐ Experienced this before

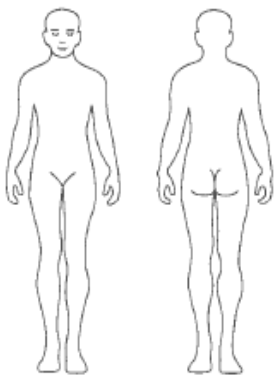
How Did It Start _____

Side of pain:	☐ Left	☐ Right	☐ Both	☐ Center	☐ None	
Intensity:	☐ Minimum	☐ Mild	☐ Moderate	☐ Severe	☐ Unbearable	☐ None
What Does	☐ Burning	☐ Dull Ache	☐ Numb	☐ Sharp	☐ Shooting	
It Feel Like:	☐ Stabbing Pain	☐ Tightness	☐ Tingling	☐ Throbbing	☐ Radiating Pain, show where on chart	
Makes Pain	☐ Acupuncture	☐ Chiropractic Therapy	☐ Heat	☐ Ice	☐ Muscle Relaxer	
Better:	☐ Massage Therapy	☐ Nothing Works	☐ Pain Medicines		☐ Physical Therapy	
	☐ Sleep/Rest	☐ Stretching	☐ Therapy		☐ Other_____	
Frequency:	☐ Constantly (76-100% of Day)	☐ Frequently (51-75% of Day)	☐ Occasionally (26-50% of Day)			
	☐ Intermittently (0-25% of Day)	☐ None				
	☐ 1-3 Days per Week	☐ 4-7 Days per Week	☐ ____ Days per Month			

Pain Interferes With: *(Check all that apply)*

- ☐ Baking
- ☐ Bathing
- ☐ Bending
- ☐ Bending Arm
- ☐ Caring of Others/Pets
- ☐ Caring for Children
- ☐ Carrying Objects
- ☐ Climbing Stairs
- ☐ Concentrating
- ☐ Cooking/Cleaning
- ☐ Crouching/Squatting
- ☐ Doctor's Visits
- ☐ Doing Hobbies
- ☐ Doing things on time
- ☐ Dressing
- ☐ Driving
- ☐ Eating
- ☐ Exercise/Sports
- ☐ Financial Management
- ☐ General Mobility
- ☐ Getting Places
- ☐ Hearing
- ☐ Holding onto objects
- ☐ Housework
- ☐ Jogging
- ☐ Keeping Balance
- ☐ Knitting
- ☐ Leaning
- ☐ Lifting
- ☐ Light/Sound
- ☐ Lying Down
- ☐ Lying on my side of pain
- ☐ Making Decisions
- ☐ Moving Joint(s)
- ☐ Personal Hygiene/Grooming
- ☐ Pushing/Pulling with Feet
- ☐ Pushing/Pulling with Hands
- ☐ Reaching Out/Up/Down
- ☐ Reading
- ☐ Running
- ☐ Seeing
- ☐ Sewing
- ☐ Sexual Activity
- ☐ Shopping
- ☐ Siting
- ☐ Speaking
- ☐ Standing
- ☐ Turning
- ☐ Twisting
- ☐ Walking
- ☐ Watching TV
- ☐ Working
- ☐ Yard Work

FRONT BACK



R / L L / R

*Label symptoms on body part.

NAME_____ DATE_____

Allergies	Please check any that apply to you.			
__Acetaminophen	__Codeine	__Latex	__Shellfish	__NONE
__Amoxicillin	__Dairy Products	__Molds	__Smoke	__OTHER:_____
__Aspirin/Pain Med.	__Dust	__Penicillin	__Sulfa Drugs	_____
__Bee Stings	__Eggs	__Ragweed/Pollen	__Wheat	_____
__Caesin Protein	__Ibuprofin	__Rudder	__X-Ray Dye	
__Chocolate/Sweets	__Iodine	__Seasonal		

Surgeries	Please check any that apply to you and please date.			
__Abdominoplasty	__Chest	__Gynecological	__Lumpectomy	__NONE
__Appendix	__C-Section	__Hand RT/LF	__Neck	__OTHER_____
__Back	__Disk - Cervical	__Heart	__Neurological	_____
__Bariatric Surgery	__Disk - Lumbar	__Heart Catheter	__Obstetrical	_____
__Brain Aneurysm	__Disk - Thoracic	__Hemrhoids	__Podiatric	
__Brain/Tumor	__EENT	__Hernia	__Prostate	__Tonsillectomy
__Breast Augmentation	__Elbow RT/LF	__Hip RT/LF	__Rotator RT/LF	__Tubal Ligation
__Carotid Artery RT/LF	__Foot RT/LF	__Hysterectomy	__Sarcoidosis	__Ureter Blockage
__Carpal Tunnell	__Gallbladder	__Kidney Removal	__Shoulder	__Varcose Veins
__Cataracts	__Gastrointestinal	__Knee RT/LF	__Splenectomy	__Vasectomy
			__Thyroid	__Wrist RT/LF

Medical History	Please check any that apply to you.			
__Anemia	__Dizziness	__Hernia	__Osteopenia	__NONE
__Ankle Pain RT/LF	__Elbow Pain RT/LF	__High Blood Pressure	__Osteoporosis	__OTHER_____
__Anxiety	__Emphysema	__High Cholesterol	__Ovarian Cysts	_____
__Arm Pain RT/LF	__Endometriosis	__Hip Pain RT/LF	__Pacemaker	_____
__Arthritis	__Epilepsy	__Jaw Pain RT/LF	__Parkinson's Disease	SMOKING STATUS:
__Asthma	__Eye/Vision Problem	__Joint Stiffness	__Pinched Nerve	CURRENT PREVIOUS
__Back Pain	__Fainting	__Kidney Disease	__Plantar Fasciitis	
__Barrett's Esophagus	__Fatigue	__Knee Pain RT/LF	__Pneumonia	
__Bi-Polar Disorder	__Fibroids	__Leg Pain RT/LF	__Polio	__Shingles
__Bleeding Disorder	__Fibromyalgia	__Liver Cancer	__Prostate Problems	__Stroke
__Broken Bones	__Foot Pain RT/LF	__Lupus	__Psychiatric Care	__Stomach Problems
__Bronchitis	__Fractures	__Lymes Disease	__Restless Leg Syndrome	__Thyroid Hashimotos
__Cancer	__Genetic Spinal Disorder	__Menstrual Problems	__Scoliosis	__Thyroid Issues
__Cataracts	__Hand Pain RT/LF	__Metoprolol	__S.T.D.	__Trigeminal Neuralgia
__Chest Pain	__Headaches	__Migraines	__Shoulder Pain RT/LF	__Tumor
__Chronic Fatigue Synd	__Hearing Problems	__Miscarriage	__Skin Cancer	__Ulcers
__COPD	__Heart Attack	__Multiple Sclerosis	__Sleep Apnea	__Vaginal Infections
__Depression	__Heart Murmur	__Neck Pain	__Spinal Cord Injury	__Weight Gain
__Diabetes	__Hepatitis	__Neurological Disorder	__Sprain/Strain	__Weight Loss
			__Stenosis of Lumbar Spine	__Wrist Pain RT/LF

Family Medical History		***Medications / Vitamins***
Relative	Condition / Disease	

DAVIS CHIROPRACTIC INC
20461 DuPont Blvd., Ste 1
GEORGETOWN, DE 19947

FINANCIAL POLICY

1) We accept cash, check, Visa and MasterCard
2) All payments are due at the time of service, unless special arrangements have been made in advance.
3) All supplements/vitamins, supports and other supplies MUST be paid for at the time they are received.
4) We will file your insurance claims for you as a courtesy but you are ultimately responsible for the payment if not paid for by your insurance within 45 days.
5) We reserve the right to charge for missed appointments. ($30)
6) A $5(monthly) fee will be added to all bills not paid after first statement.
7) You will be responsible for all collection fees if for any reason this account is turned over for non-payment.
8) Patient is responsible for their own referrals, obtaining and keeping track of dates.

Workers compensation claims

9) All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage.

***** Please keep in mind you are ultimately responsible if not paid within a reasonable time.

Personal Injury/Motor Vehicle Accidents

10) Personal injury and auto accident cases will be billed to your auto insurance co., providing that a claim has been filed and the appropriate paper work has been done
11) If you choose not to file a claim with your auto insurance, or are uninsured, your account will be treated as a cash account and all fees will be due at time of service.
12) Generally supplements/vitamins, supports and other supplies are not covered by insurance companies, and must be paid for when received. Should the insurance company pay, we will reimburse you for the amount you paid.
13) This office will file Workman's compensation and Automobile Accident claims but it is up to the patient to handle any non-payment issues from the insurance Company.

I have read, understand and agree with the above financial policy.

_____ _____

Patient/Guardian signature **Date**

INFORMED CONSENT TO CHIROPRACTIC CARE

DAVIS CHIROPRACTIC, INC.

JOHN C. DAVIS, D.C.

HAROLD L. ADKINS D.C.

20461 DuPont Blvd. Ste 1

Georgetown, DE 19947

Phone: 302-856-2225 Fax: 302-856-6618

Patient Name _____ Birthdate _____

Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand an am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I understand that I may be receiving any or all of the following treatments:

- Chiropractic Manipulation
- Percussive Massage
- Spinal Exercises
- Spinal Traction
- Ultra Sound and Electrical Muscle Stimulation
- Decompression Therapy.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Signature of Patient/Parent/Guardian/ Personal Representative Date

_____ _____

Please print name of Patient/Parent/Guardian/Personal Representative Relationship to Patient

Witness Signature _____ Date _____

Doctor's Signature _____ Date _____