the Health & Wellness clinic

**Dr. Jenni Ricker, DC**

22005 76th Ave. W.
Edmonds, WA 98026

**425.776.3800**
425.776.3844 Fax

*www.thehealthandwellnessclinic.com*

# CONFIDENTIAL PATIENT INFORMATION

## CONTACT INFORMATION

Date _____ Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone (  ) _____ Work # (  ) _____ Cell # (  ) _____

Email _____ Occupation _____ Employer _____

Age_____ Ht._____ Wt. _____ Circle: Male / Female / Single / Married / Divorced / Widowed

Social Security # _____ Spouse's name _____

Do you have children? ❑ Yes ❑ No Names/Ages _____ _____ _____

Who may we thank for referring you to our office? _____

**PAYMENT IS EXPECTED AT THE TIME OF VISIT.**

Name of Person Responsible for Payment: _____

ARE YOU INSURED? ❑ Yes ❑ No

Insurance Company: _____ (Please provide us your insurance card to make a copy.)

## REASON FOR VISIT

Describe your present complaint: _____

How long have you had this condition? _____ Date Began: _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and Goes

Have you had this similar condition before? ❑ Yes ❑ No When? _____

Have you seen any other doctors for this condition? ❑ Yes ❑ No Who? _____

Was the injury related to: ❑ Work Accident ❑ Auto Accident

## MEDICATIONS

Are you taking any medication or supplements? ❑ Yes ❑ No

❑ Pain killers ❑ Muscle relaxers ❑ Blood pressure ❑ Insulin ❑ Depression ❑ Anti-inflam ❑ Aspirin ❑ Tylenol ❑ Ibuprofen

Please List: 1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

## ADDITIONAL INFORMATION

**From birth to present, please list by date and describe any of the following:**

Surgeries: _____ _____ _____

Car Accidents: _____ _____ _____

Falls/Injuries: _____ _____ _____

**For women** - Are you pregnant? ❑ Yes ❑ No

HEALTH HABITS:

Sleep (hours per night) _____ Coffee/Tea (cups per day) _____

Alcohol (drinks per week) _____ Cigarettes/Tobacco (packs/times per day) _____

Social drugs: ❑ Yes ❑ No Exercise Frequency: _____ Duration: _____

## HEALTH HISTORY

**Check any of the following diseases you have had.**

- ❑ Appendicitis
- ❑ Malaria
- ❑ Chicken Pox
- ❑ Alcoholism
- ❑ Scarlet fever
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Venereal infection
- ❑ Diphtheria
- ❑ Whooping cough
- ❑ Cancer
- ❑ Arthritis
- ❑ Typhoid fever
- ❑ Anemia
- ❑ Heart Disease
- ❑ Epilepsy
- ❑ Pneumonia
- ❑ Measles
- ❑ Gout
- ❑ Goiter
- ❑ Mental disorder
- ❑ Mumps
- ❑ Rheumatic fever
- ❑ Influenza
- ❑ Lumbago
- ❑ Eczema
- ❑ Polio
- ❑ Small Pox
- ❑ Pleurisy
- ❑ HIV

**Check any of the following you have or have had in the past 6 months:**

MUSCULO-SKELETAL PROBLEMS:

- ❑ Low Back Pain
- ❑ Mid-back Pain
- ❑ Neck Pain
- ❑ Headache
- ❑ Arm Pain
- ❑ Hand Pain
- ❑ Leg Pain
- ❑ Foot Pain
- ❑ Jaw/teeth
- ❑ Muscle Weakness / Pain / Spasm

NERVOUS SYSTEM PROBLEMS:

- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Tingling
- ❑ Forgetful
- ❑ Accidents/Falls
- ❑ Convulsions
- ❑ Loss of Sleep
- ❑ Depression
- ❑ Confusion
- ❑ Broken Bones
- ❑ Knocked Unconscious

IMMUNE SYSTEM PROBLEMS:

- ❑ Hay fever
- ❑ Allergies
- ❑ Frequent Colds/Flu
- ❑ Fatigue

GASTRO-INTESTINAL PROBLEMS:

- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Liver Trouble
- ❑ Gall Bladder Problems
- ❑ Vomiting
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Blood in Stool
- ❑ Heartburn
- ❑ Gas / Bloating after meals
- ❑ Colitis
- ❑ Constipation

CARDIO-VASCULAR PROBLEMS:

- ❑ Shortness of Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Bruise Easily
- ❑ Heart Problems
- ❑ Lung Problems / Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Chest Pain
- ❑ Smoker

EAR, EYES, NOSE, AND THROAT PROBLEMS:

- ❑ Hearing Difficulty
- ❑ Ear Aches
- ❑ Vision problems
- ❑ Stuffy Nose
- ❑ Sore Throat
- ❑ Dentures
- ❑ Ringing in ears
- ❑ Dry / watery / irritated eyes

GENITO-URINARY PROBLEMS:

- ❑ Menstrual irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal pain / Infections
- ❑ Breast Pain / Lumps
- ❑ Genital Herpes
- ❑ Prostate problems
- ❑ Sexual Dysfunction
- ❑ Pregnant
- ❑ Difficulty Urinating
- ❑ Painful Urination
- ❑ Frequent Urination
- ❑ Strong urine odor / color
- ❑ Blood in Urine
- ❑ Bed wetting
- ❑ Incontinence

## SIGNATURE FOR CONSENT

**Consent for Treatment and Release of Information:**

*I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that The Health & Wellness Clinic, PLLC will prepare any necessary documents to assist me in making collection from the insurance company and that any amount authorized to be paid directly to The Health & Wellness Clinic, PLLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for making payment.*

I hereby authorize and release the doctor and whomever he/she designates as his/her assistant to administer treatment, physical examination, X-Ray studies, chiropractic care or any clinic services that he/she deems necessary in my case. I further authorize him/her to disclose all or any part of my patient records to any person or corporation which is or may be liable under a contract in the clinic or to a family member or employer of the patient for all or part of the clinic's charge, including but not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, and welfare funds. This authorization expires 48 months from the date signed below.

Signature:_____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____

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# HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the Doctor by providing past health information for her review.

| Condition | Self | Father | Mother | Spouse | Brothers | Sisters | Children |
|---|---|---|---|---|---|---|---|
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Back Trouble | | | | | | | |
| Cancer | | | | | | | |
| Constipation | | | | | | | |
| Diabetes | | | | | | | |
| Diarrhea | | | | | | | |
| Disc Problems | | | | | | | |
| Emphysema | | | | | | | |
| Epilepsy | | | | | | | |
| Headaches | | | | | | | |
| Heart Trouble | | | | | | | |
| High Blood Pressure | | | | | | | |
| Irritable | | | | | | | |
| Kidney Trouble | | | | | | | |
| Migraine | | | | | | | |
| Nervousness | | | | | | | |
| Neuralgia | | | | | | | |
| Pinched Nerve | | | | | | | |
| Scoliosis | | | | | | | |
| Sinus Trouble | | | | | | | |
| Smoker | | | | | | | |
| Sports Activities | | | | | | | |
| Stomach Trouble | | | | | | | |
| Tremors | | | | | | | |
| Work-a-holic | | | | | | | |
| Deceased | | | | | | | |

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Privacy Officer: Jennifer Ricker, DC

Effective Date: January 1, 2008

I hereby acknowledge that I have seen and been offered a copy of the Privacy Practices for the above chiropractic office.

Patient Signature _____ Date _____

Print Name _____

If not signed by the patient, please indicate relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient

Name of Patient _____

Please complete the following only if the patient refuses to sign the Acknowledgment:

Efforts to obtain: _____

Reason for refusal: _____

## ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
### PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: _____

Insured: _____

Group #: _____ SS #: _____

I hereby instruct and direct that _____ Insurance Company to pay by check made out and mailed to:

**The Health & Wellness Clinic, PLLC, 22005 76th Ave. W., Edmonds, WA 98026**

Or

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: **c/o The Health & Wellness Clinic, PLLC, 22005 76th Ave. W., Edmonds, WA 98026**

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Policy Holder's Signature _____ Date _____

Signature of Claimant, if other than Policy Holder _____ Date _____

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# OFFICE POLICIES

## APPOINTMENTS

When appointments are made, that time has been reserved for you. As a courtesy we ask that if you will be unable to keep your scheduled appointment that you call 24 hours prior to your appointment to reschedule. If not, we reserve the right to charge $25.00 for missed appointments.

**Initials** _____

## SERVICES AND SUPPLIES

All orthopedic supplies and nutritional supplements must be paid for when received.

**Initials** _____

## PAYMENTS

Payment is expected for all services when rendered unless prior arrangements have been made. Payment plans are available and my staff will be happy to discuss them with you. For those who have insurance, as a courtesy, we will verify your insurance coverage at the beginning of your care. However, **We Can Not Guarantee Benefits.** You should refer to your insurance website or call to verify your benefits yourself. Your carrier does not guarantee the benefits they describe to us over the phone. Claims must be submitted and reviewed.

**Please Note:** Authorization by a utilization review board does not guarantee payment of those visits authorized. You are responsible for knowing your insurance limits, maximums and restrictions. Your care is not based on the number of visits your insurance carrier may authorize, but on the care most appropriated for your condition. We will also bill directly to your insurance carrier for you as a courtesy and make every attempt to see your claims are paid. If problems occur, we will not enter into any dispute over unpaid claims with your insurance carrier. The contract is between you and your carrier and is your responsibility. All unpaid claims are your financial responsibility. All deductibles and co-payments are due at the time of your visit.

**Initials** _____

It is part of our standard billing practice to file a lien in all cases where the patient is receiving treatment for injuries due to a third party.

**We would like to take this opportunity to welcome you and thank you for choosing our clinic. Our primary concern is to provide you with quality chiropractic care. We welcome your referrals as we are a growing practice.**

Please If you have any questions or concerns feel free to ask us. My staff is always available to answer your questions and help in any way they can.

**Patient Signature** _____ **Date** _____