WELCOME TO TOMPKINS CHIROPRACTIC

Last Name: _____ First Name: _____ M.I.: ____
What name do you prefer to go by? _____
Address: _____ APT #: _____
City: _____ State: _____ Zip Code: _____
Email (for office use only): _____
Home Phone: (_____) _____ Work Phone: (_____) _____EXT_____
Cell Phone: (_____) _____ Fax Line: (_____) _____
Date of Birth: ____/____/____ Sex: ☐ M ☐ F SSN: _____ Height _____ Weight _____
Spouse's name: _____ _____ Phone: (_____) _____
Emergency contact other than Spouse:
Name: _____ Relation: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
How did you hear about us/whom may we thank for referring you? _____

Have you had an accident (major or minor) within the past 2 years? ☐ NO ☐ YES
If yes, what type of accident? ☐ AUTO ☐ WORK ☐ OTHER: _____
If yes, what date and time did this accident occur? ____/____/____ _____:_____ am pm
If you are seeking care due to an accident it is possible care may be provided at no out of pocket cost to you. If seeking care due to an injury please ask the front desk for the "accident questionnaire" at the time.
Are you seeking care due to an auto of work injury? ☐ NO ☐ YES Initial Here: _____

Do you have primary health insurance policy? ☐ NO ☐ YES
Do you have a secondary health insurance policy? ☐ NO ☐ YES
If yes, please provide the front desk with your health insurance card(s) at this time and our office will inform you of your coverage. ***Most insurance companies cover our services.***
Policy Holder's Name: _____ Date of Birth: ____/____/____ SSN: _____
Relation to Policy Holder: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____
Your Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Legally Separated
Your Student Status: ☐ Full-time ☐ Part-time ☐ Non-student
Your employment status: ☐ Full-time ☐ Part-time ☐ Retired
Your Employer: _____ Spouse's employer, if married: _____
I realize my health insurance company will be billed as a service to me. Until my benefits can be verified, I will be responsible for payment of care today. If I have coverage, the amount I pay will be applied to my deductible and/or my daily co-insurance payments. If I do not have coverage the doctor will discuss an affordable plan with me. I may also be asked to help pursue the insurance company in small claims court if necessary. Initial Here: _____

Your initial visit today will include an extended evaluation with Dr. Matthew Tompkins, D.C. If necessary, x-rays will be taken.

☐ CASH ☐ CREDIT CARD ☐ CHECK

_____ _____ ____/____/____
Signature of Patient/Guardian **Print Name** **Date**

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Name: _____ Date: _____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

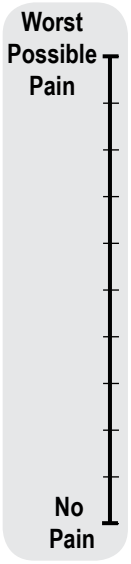
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

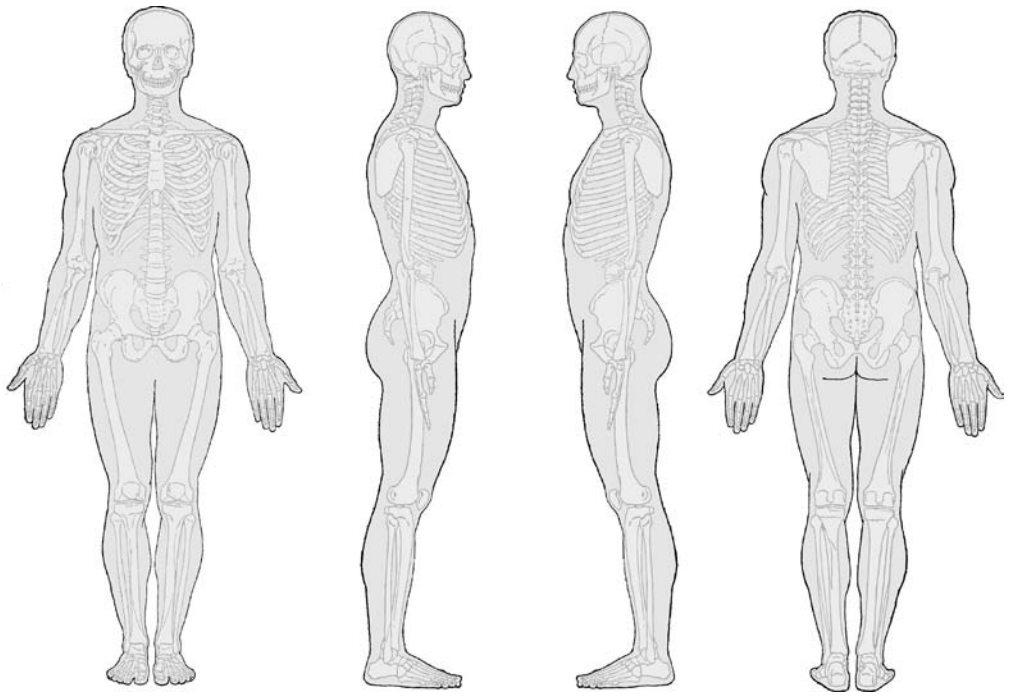
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

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Tompkins Chiropractic

Automobile Accident Questionnaire

Accident Information

Name:_____ Date:_____

1. Date of Accident: _____ Time:_____ a.m./p.m.

2. Driver of car: _____ Where you were seated:_____

3. Owner of car: _____ Year and Model of car:_____

4. Visibility at time of accident: poor/fair/good/other: _____

5. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: _____

6. Where was your car struck? right/left/rear/front/side/other: _____

7. Type of accident: ☐ head-on collision ☐ broad-side collision ☐ rear-end collision

☐ front impact, rear-ended car in front ☐ non-collision: _____

8. What part of the car was damaged? _____

9. Describe what happened to you upon impact? _____

10. Did you see the accident was about to happen? ☐ Yes ☐ No

11. Did you brace for impact? ☐ Yes ☐ No

12. Were you wearing a seatbelt? ☐ Yes ☐ No

13. Were you wearing a shoulder harness? ☐ Yes ☐ No

14. Does the car have headrests? ☐ Yes ☐ No

15. If yes, what was the position of your headrest? ☐ top of headrest even with bottom of head

☐ top of headrest even with top of head ☐ top of headrest even with middle of head

16. Was your car braking? ☐ Yes ☐ No Was the other car braking? ☐ Yes ☐ No

17. Was your car moving at the time of the accident? ☐ Yes ☐ No

If yes, how fast would you estimate you were going? _____

18. How fast would you estimate the other car was traveling? _____

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Name: _____ Date: _____

19. What was the position of your head and body at the time of impact?

☐ head turned left/right ☐ body straight in sitting position ☐ head looking back

☐ body rotated left/right ☐ head straight forward ☐ other:_____

20. At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

21. As a result of the accident were you: ☐ rendered unconscious ☐ dazed ☐ other: _____

22. Could you move all parts of your body? ☐ yes ☐ no

If no, why not? _____

23. Were you able to get out of the car and walk unaided? ☐ yes ☐ no

If no, why not? _____

24. Did you have any cuts or bruises from this accident? ☐ yes ☐ no

If so, where? _____

25. Describe how you felt immediately after the accident? _____

_____

How did you feel later that ☐ day ☐ night? _____

How did you feel the next day(s)? _____

26. Check symptoms apparent <u>since</u> the accident:

☐ headache	☐ loss of smell	☐ numbness in fingers	☐ neck pain/stiffness
☐ loss of taste	☐ cold hands	☐ mid-back pain	☐ loss of memory
☐ cold feet	☐ low-back pain	☐ fatigue	☐ diarrhea
☐ tension	☐ constipation	☐ pain behind eyes	☐ shortness of breath
☐ chest pain	☐ dizziness	☐ irritability	☐ nervousness
☐ fainting	☐ depression	☐ cold sweats	☐ anxious
☐ sleeping problems	☐ loss of balance	☐ numbness in toes	
☐ ringing/buzzing in ears		☐ eyes sensitive to light	☐ other:_____

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Name: _____ Date: _____

27. Have you missed time from work? ☐ yes ☐ no Work hours are: ☐ full-time ☐ part-time

If you have missed time from work, how much time have you missed? _____

28. Did the accident occur during your work hours? ☐ yes ☐ no

29. Did you seek medical help immediately/soon after the accident? ☐ yes ☐ no

If yes, how did you get there? _____

30. Doctor/hospital/clinic seen: _____ Date: _____

31. What was done? _____

Were x-rays taken? ☐ yes ☐ no If yes, of what body part? _____

32. What treatments/prescriptions were given? ☐ bed rest ☐ brace ☐ adjustments ☐ medications

33. What benefit(s) did you receive from treatment(s)? _____

_____

34. Date of last treatment: _____

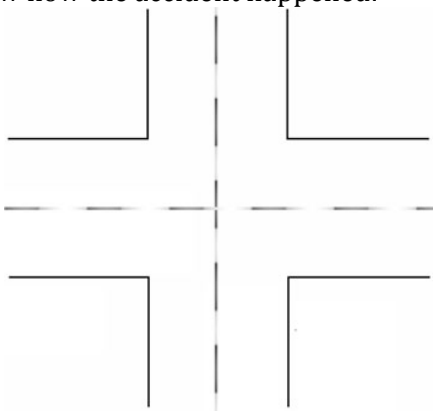
35. Are any of your activities of daily living any different now compared to before the accident?
☐ yes ☐ no

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

36. Indicate on the diagram below how the accident happened:



Comments: _____

_____

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Name: _____ Date: _____

_____

_____

_____

37. Do you have an attorney handling this case? ☐ yes ☐ no

If yes, who? (name/address)_____

_____

Insurance Information

Patient's personal insurance: _____

Insured's name (if other than patient) _____

Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____City: _____State/Zip:_____

Claim #: _____Adjuster's name/phone:_____

_____

Other party's insurance: _____

Insured's name (if other than patient) _____Policy #: _____

Insurance Company Name: _____Phone#: _____

Address: _____City: _____State/Zip: _____

Claim #:_____Adjuster's name/phone: _____

Other insurance: _____

Insured's name (if other than patient) Policy #: _____

Insurance Company Name: _____

Phone#: _____

Address: _____City: _____State/Zip: _____

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Name: _____ Date: _____

Claim #: _____

Adjuster's name/phone: _____

Patient's Demographic Information
Patient's full name: Social Security #: _____

Address: _____

Date of Birth: _____

Mailing address (if different): _____

Phone: _____

Employer name: _____

Spouse's Occupation: _____

Employer's address: _____

Work phone: _____

Spouse's name: _____

Spouse's Social Security #: _____

Spouse's employer: _____

Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Tompkins Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Tompkins Chiropractic the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Tompkins Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____

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Tompkins Chiropractic LLC
595 SW Bluff Dr, Suite A
Bend, Or 97702
Office: 541.647.2797 Fax: 541.388.2606

Patient name:_____

Authorizations and Releases

Authorizations and Releases

Patient Health Information and Privacy Policy (HIPAA)

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/downloads/HIPAALaw.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.

2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.

3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.

4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.

5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.

6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Initial _____ Signature _____ Date _____

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