

# Baxter Village Health Center New Patient Information

*(To be completed by all new patients receiving Chiropractic, K-Laser, Reflexology, Acupuncture, Massage Therapy, and Physical Therapy)*

## Patient Data

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
           First                  Middle Initial                  Last                  MM          DD          YYYY

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: Male/Female                      Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: Single    Married    Divorced    Widow    Other: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_                      Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_                      Email Address: \_\_\_\_\_

May we contact you via email? Y/N

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Referral Information

*(How did you hear about us OR who referred you to us?)*

Friend/Family: _____	Lotus Pilates & BodyWorks	Community Event
May we contact them to say "thank you" for referring you? Y or N	Internet Search	Social Media
Physician: _____	Print Advertising	Word of Mouth
May we contact them to say "thank you" for referring you? Y or N	Other: _____	

## Insurance Information

*(Not all services rendered are covered by insurance)*

Policy holder: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibilities for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I also acknowledge it is my responsibility to obtain all referrals my insurance may require (ie. many insurance companies require a referral from a physician to continue seeing a physical therapist 30 days after the initial visit).

Patients's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*(Parent or Guardian if patient is a minor)*

Baxter Village Health Center  
Insurance Assignment

*Must be signed by all who wish to go through insurance now or in the future.*

I, \_\_\_\_\_, request, authorize and further direct that any insurance company which is liable for reimbursement for services rendered make payments directly to you, I request payment of government or medical benefits to the undersigned physician's office below. I further authorize and give my permission for you to endorse checks, drafts and payments received in my behalf for medical services rendered. It is further understood that if any point the monies received exceed my indebtedness, these funds will be returned to me by your office and it is my responsibility to comply with any subrogation clause which may be contained in my medical insurance.

I hereby assign and transfer to you any cause of action that exists in my favor against such company and authorize you to prosecute said actions, either in my name or your name, as you see fit. It is agreed, however that in transferring this cause of action it is agreed between all parties that your interest in this case shall be limited to the amount of medical bills rendered to me by you and your appointee. It is further understood and agreed by all parties that the transfer of this cause shall be limited to medical bills rendered on my behalf and that are related only to the case in question. For the above named purpose, I further authorize and transfer to you my limited power of attorney so that you may act in my behalf in this regard, and this regard only. It is agreed that you will make all reasonable efforts to collect sums due from the insurance carriers with a liability in this case; however, it is my ultimate responsibility to pay in full for all services rendered to me.

I hereby state and agree to this authorization and assignment may not be withdrawn unilaterally.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_  
*(Parent or Guardian if patient is a minor)*

Witness Signature: \_\_\_\_\_

Cancellation Policy

*(To be completed by all new patients receiving Chiropractic, K-Laser, Reflexology, Acupuncture, Massage Therapy, and Nutritional Therapy)*

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to cancellation fee of 50% of the full cost of the originally schedule service, (i.e a 60 minute massage is \$75 therefore cancellation fee would be \$37.50).

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management and provider approval.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_  
*(Parent or Guardian if patient is a minor)*

Witness Signature: \_\_\_\_\_

*If you feel inspired to leave your massage therapist or reflexologist a tip, please inform the front desk prior to running your credit card as we do not have a "tip line" available on your receipt. Thank you!*

## Medical/Health History

*(To be completed by all new patients receiving Chiropractic, K-Laser, Reflexology, Acupuncture, and Massage Therapy)*

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems may affect your overall course of care. Please circle if you are currently experiencing or have a history of the following:

Alcoholism	Allergies	Anemia	Arteriosclerosis	Dental Concerns
Arthritis	Asthma	Back Pain	Paralysis	Autoimmune Disease(s)
Bronchitis	Bruise Easily	Cancer	Chest Pain/Condition	Hearing Difficulties
Cold Extremities	Constipation	Cramps	Depression	Bladder Difficulties
Diabetes	Digestive Problems	Dizziness	Ear Ringing	TMJ/TMD
Emphysema	Epilepsy	Gout	Heart Disease	Sexual Dysfunction
Excessive Menstruation	Eye Pain/Difficulties	Fatigue	Frequent Urination	Infertility Concerns
Headaches	Hemorrhoids	High Blood Pressure	Hot Flashes	Whooping Cough
Hepatitis A, B, or C	Hypoglycemia	Injuries	Intestinal Parasites	Chicken Pox
Irregular Heart Beat	Irregular Cycle	Kidney Infection	Kidney Stones	Poor/Excessive Appetite
Loss of Memory	Loss of Balance	Loss of Smell	Loss of Taste	Anxiety
Low Blood Pressure	Appendicitis	Bleeding Disorder	Emotional Difficulties	Dry Mouth
Multiple Sclerosis	Mumps	Pacemaker	Weight Loss/Gain	Women:
Neck Pain/Stiffness	Nervousness	Nosebleeds	Poor/Excessive Thirst	Date of last menses?
Polio	Poor Posture	Prostate Difficulties	Sciatica	Are you pregnant?
Scarlet Fever	Surgery	Ulcer	Vision Problems	If so, due date:
Shortness of Breath	Sinus Infection	Sleep Problem or Insomnia	Spinal Curvature	# of Pregnancies:
Stroke	Swelling of Ankles	Swollen Joints	Thyroid Condition	___ births ___ miscarriages
Tuberculosis	Ulcers	Varicose Veins	Venereal Disease	Type and date of delivery(ies):

Other: \_\_\_\_\_

If you answered yes to any of the above please explain: \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ If so, please list the reason: \_\_\_\_\_

Caffeine _____ X per day OR week	Refined Sugar _____ X per day OR week
Tobacco _____ X per day OR week	Alcohol _____ X per day OR week
Drugs _____ X per day OR week	Soft Drinks _____ X per day OR week
Water _____ X per day OR week	Exercise _____ X per day OR week
Artificial Sweeteners _____ X per day OR week	

List of current medications and/or supplements (include dosage if known): \_\_\_\_\_

I have provided correct and complete information to the best of my knowledge and understand it is my responsibility to update my provider in the event there are any changes.

Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Diagram Of Concern**

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A = Ache

B = Burning

N = Numbness

O = Other

P = Pins & Needles

S = Stabbing

