Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Date: _____

Confidential Patient Information (updated 6/26/24)

Patient Name: _____ Preferred Name: _____

Address: _____ Cell Phone: _____

City: _____ State/Zip:_____ Home Phone: _____

SS#: _____ Birth Sex: Male Female

Date of Birth: _____ Marital Status: M S W D # children: _____

Email:_____ Occupation: _____

Address of Insured (if different than above): _____

****Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury?** (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____ **Who is responsible for the bill?**_____

- How did you hear about our office? _____
- Have you had Chiropractic Care previously? _____ If yes, have you been adjusted with an instrument? ***Yes*** ***No***
- What style adjustment do you prefer? ***Manual*** ***Pulstar (tool)*** ***Activator (tool)*** ***Both***
- Would you like to receive appointment reminders: ***yes*** ***no***

EMERGENCY CONTACTS

Name: _____ Relationship:_____ Phone number: _____

May we release Protected Health Information (PHI) to this individual? YES NO

Name: _____ Relationship:_____ Phone number: _____

May we release Protected Health Information (PHI) to this individual? YES NO

CONFIDENTIAL COMMUNICATION

In addition to mail, I also prefer to communicate confidentially via: (choose one)

- ☐ **Cell phone**
- ☐ **Home phone**
- ☐ **Email**

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Patient Name_____ **DOB** _____

1. Circle the severity (0 = No Symptoms to 10 = Very Severe) and Frequency of symptoms (% of the week you experience the pain).

Condition / Problem Please list all problems below	**Severity** Minimal → Severe	**Frequency (% of week)** Occasional → Constant
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

2. Symptoms are **worse** in the **(circle what applies)** *morning* *afternoon* *night* *None*
   Increases during the day *same all day* *decreases during the day*
3. When did your symptoms begin? _____
4. How did your symptoms begin? What were you doing?

   _____

   _____
5. What is the quality of pain? **(circle all that apply)** *Sharp* *Dull* *Achy* *Pins & Needles* *Tightness*
6. Do your symptoms radiate into your legs or arms? *NO* *YES*
7. Has your condition? *Improved* *Gotten Worse* *Stayed the same*
8. Is this condition interfering with: *Work* *Sleep* *Daily Routine* *Recreation* *None*
9. Circle what make your problems worse:
   Bending *Lying down* *Walking* *Standing* *Sitting* *Movement* *Twisting* *Lifting* *None*
10. Have you experienced these symptoms before? *NO* *YES* If yes, When & what treatment did you do? What was the result?_____
11. Is there anything that offers relief? *NO* *YES* *I have not tried anything*
    Describe what **has** or **hasn't** helped: _____
12. Have you had any surgeries? *NO* *YES* **please list with date**:_____

    _____
13. Do you take medication, vitamins, or mineral supplements? *NO* *YES* **(please list)**

    _____
14. Family Health History: Many health problems are a result of hereditary spinal weakness. Information about your family members gives us a better understanding of your total health. Please list your family history below or *NONE*

Relationship		**Past and present health problems**

Patient Signature: _____ **Date:** _____

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Patient Name: _____ **D.O.B.** _____

Do you have or have you had any of the following?

Constitutional

- ☐ Allergies
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Loss of Sleep
- ☐ None

Cardio-Vascular

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pain over heart
- ☐ Poor Circulation
- ☐ None

Eyes, Ears, Nose & Throat

- ☐ Asthma
- ☐ Colds
- ☐ Sinus Infection
- ☐ Earache
- ☐ Ear Noises
- ☐ None
- ☐ Eye pain
- ☐ Failing Vision
- ☐ Nosebleeds
- ☐ Sore Throat

Muscle & Joint

- ☐ Arthritis
- ☐ Foot Trouble
- ☐ Disc Problems
- ☐ Spinal Curvature
- ☐ None

Gastro- Intestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Sinus Infection
- ☐ Difficult Digestion
- ☐ Gallbladder Trouble
- ☐ None
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Pain over Stomach
- ☐ Vomiting

Mental Health

- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ None

Respiratory

- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficult breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing
- ☐ None

Genito-Urinary

- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Inability to control bladder
- ☐ Kidney Infection/ Stones
- ☐ Painful Urination
- ☐ Prostate Trouble
- ☐ None

For Women Only

- ☐ Cramps/ Backache
- ☐ Hot Flashes
- ☐ **Pregnant: currently**
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Painful Menstruation
- ☐ None

Patient Signature: _____ **Date:** _____

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Patient Name: _____ **D.O.B.** _____

Do you have or have you had any of the following?

- ☐ Alcoholism
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Influenza
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Parkinson's
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ None
- ☐ None

Have you been in an auto accident?

- ☐ Past year
- ☐ Past 5 years
- ☐ Over 5 years
- ☐ Never

Have you ever been knocked unconscious?

- ☐ No
- ☐ Yes: explain

Have you ever fractured a bone?

- ☐ No
- ☐ Yes: Where & When?

Do you have any allergies?

- ☐ Food
- ☐ Medication
- ☐ Seasonal
- ☐ Latex
- ☐ None
- ☐ Other

Do you wear any of the following?

- ☐ Heel Lifts
- ☐ Arch Supports
- ☐ Back Brace
- ☐ Neck Brace

Do you exercise?

- ☐ No
- ☐ Yes

Do you drink Alcohol?

- ☐ No
- ☐ Yes: how much?

Do you drink coffee/caffeinated drinks?

- ☐ No
- ☐ Yes: how much?

Do you smoke?

- ☐ No
- ☐ Yes: how much?

Do you use drugs or CBD?

- ☐ No
- ☐ Yes: what & how much?

Patient Signature: _____ **Date:** _____

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Financial Policy and Consents

At Sunbury Chiropractic Center, Inc., our mission is "Relief First, Wellness Always." Our recommendations for care are based on a desire to see you get well and stay well with maintenance care. Chiropractic care is covered under many insurance plans, personal injury coverage, worker's compensation coverage, Medicare, and Medicaid. **All medical concerns are to be discussed with the doctor and all financial concerns are to be discussed with office staff.** We accept Visa, Mastercard, Discover, Care Credit, and will be happy to extend a payment plan. We require payment every month for any balance on the account or future appointments may not be scheduled. If you feel you might qualify for our financial hardship policy, please notify office staff regarding an application. Should payment be refused by your bank for a check written, the office will charge a fee of $36 to offset the charges we will incur. The privilege of insurance assignment begins when our office receives and verifies your insurance information. This service is a courtesy to you and is not a guarantee of coverage. We always recommend your participation in verifying your own chiropractic coverage, too. Your insurance policy is a relationship between you and your insurance provider. State law allows insurance carriers to retract or correct processing of claims for up to 2 years from the date of service. If you are not enrolled in a health plan or not seeking to file a claim with your plan, this office is required to provide you with a "Good Faith Estimate" under Section 2799B-6 of the Public Health Service Act. If you receive a bill that is at least $400 more than your estimate, you can dispute the bill through the patient-provider dispute process. **All treatments considered maintenance are generally not covered benefits and could be the responsibility of the patient.**

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance health care benefits and hereby assign at clinic's request, and pay directly to **Sunbury Chiropractic Center, Inc** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or health benefits claim submissions. If I do not have insurance, I will pay at the time the services are rendered.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit or appeals with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

CONSENT TO TREAT

A patient gives the doctor permission and authority to care for them in accordance with the chiropractic tests, diagnosis, and analysis. Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. I understand I can refuse any service in the office. If declined, the doctor will advise an alternative to treatment for the safety of my condition. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses, deformities, use of recreational drugs/alcohol or use of CBD oil which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. If during care, non-chiropractic or unusual findings are encountered, the doctor will advise the patient of those findings and recommend that service be sought by another health care provider. Chiropractic care may or may not improve a condition. The patient will always be made aware of alternatives to chiropractic treatment.

I understand that if I am accepted as a patient by a physician at **Sunbury Chiropractic Center, Inc.**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request or new diagnosis. With signature, I consent to the examination, diagnostic x-rays, chiropractic adjustment and any ancillary procedures such as physiotherapy and/or rehabilitative procedures.

I have read and fully understand the CONSENTS ON THIS PAGE.

Patient/Guardian Signature: _____ Date: _____

PRINT Name: _____ DOB: _____

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Chiropractic Appointments: Our doctors' schedules are extremely busy. To provide you sufficient time with the doctor, we ask that you call the office 24 hours in advance or as soon as possible if you will not be able to make your appointment or need to reschedule. This allows us time to schedule another patient that may be on a wait list. If you are more than 15 minutes late, you may be asked to reschedule your appointment.

Massage Missed Appointments: There is a $25 fee charged for all **MASSAGE** appointments that are not canceled 24 hours prior to scheduled appointment.

X-RAY OVERREAD: I understand that my doctor may submit my x-rays to ETS Chiropractic Consulting, PLLC for radiological evaluation and analysis by a Chiropractic Radiologist. **There will NOT be a fee for this second opinion**, as Sunbury Chiropractic Center will cover all costs as a courtesy.

Eric T. Stefanowicz, DC, MS, DACBR
16200 Amber Valley Dr.
Whittier, CA 90604
Office: 562-947-8755

NOTICE OF PRIVACY PRACTICES: I have been offered the copy of Notice of Privacy Practices which outlines how my Protected Health Information may be used and disclosed, and how I can get access to the information.

☐ **Yes and received**

☐ **Offered but Declined**

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MINOR ONLY: Consent to Evaluate and Treat a Minor

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic adjustment, therapy, evaluation and/or diagnostic x-rays by any doctor or office staff with or without a parent or guardian present.

□ Mother/Legal Guardian:_____

□ Father/Legal Guardian:_____

I understand that information will be disclosed to all parents or guardians unless court documents are presented stating otherwise. All legal guardians need to submit court documents to our office to prove guardianship. I understand that some insurance plans consider spinal manipulation on children under the age of 2 years to be experimental and may not be covered. By signing this, you understand that your child's visit, if applicable, may be denied by the insurance company and you will be financially responsible for all denied services rendered.

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I have read and fully understand the consents on this page.

Patient/Guardian Signature: _____ Date: _____

PRINT Name: _____ DOB: _____