Wilkinson Clinic of Chiropractic
115 E. Waverly Street, Morris, IL 60450
Phone: (815) 942-5350 Fax: (815) 942-5414

Date_____
Account # _____
X-ray #_____

Patient Demographics Form

Please note: Our new extensive entrance form is necessary for compliance with the Health Care Financing Administration and the National Committee for Quality Assurance's new standards. Please fill it out completely.

Name_____ Preferred Phone [Home/Cell] ( ) _____

Address_____ City_____ State_____ ZIP_____

Age _____ Birthdate _____/_____/_____ Social Security # _____ Email_____

Gender M / F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Student

Occupation _____ Employer _____ Work Phone ( ) _____

Emergency Contact _____ Phone ( ) _____ Relationship _____

Date of Last Physical Exam _____ Referred By _____

Patient's Primary Care Physician _____ Permission to Contact Yes / No

Insurance Information

Policy Holder Name_____ Birthdate _____/_____/_____ Phone ( ) _____

Address_____ City_____ State_____ ZIP_____

Relationship to Patient _____ Policy Holder's Social Security # _____

Employer Name_____ Work Phone ( ) _____

Insurance Company Name _____ Insurance Co. Phone ( ) _____

Insured's ID Number _____ Group Number _____

Is patient covered under any other insurance? Yes / No If yes, please complete the following:

Secondary Insurance

Policy Holder Name_____ Birthdate _____/_____/_____ Phone ( ) _____

Address_____ City_____ State_____ ZIP_____

Relationship to Patient _____ Policy Holder's Social Security # _____

Employer Name_____ Work Phone ( ) _____ ext.____

Insurance Company Name _____ Insurance Co. Phone ( ) _____

Insured's ID Number _____ Group Number _____

History of Current Problem:

Please describe your current problem._____

Is your current problem the result of: Auto Accident? Yes / No Work Accident? Yes / No

How did your problem begin? _____

Date problem began _____ Other doctors seen for this condition_____

List other treatments or tests you've had for this condition_____

Have you been treated by a physician for any other health condition in the last year? Yes / No If yes, please explain:

_____

How often are your symptoms present? __Constantly __ Frequently __ Occasionally __ Intermittently

Describe your current paint/symptoms: __Sharp __Burning __Throbbing __ Shooting
__Soreness __Numbness/Tingling __Weakness

Since it began, is your problem: __Improving __Getting Worse __No Change

What makes the problem better? __Nothing __Lying Down __Standing __Walking __Sitting
__Movement __Exercise __Inactivity/Rest __Other_____

What makes the problem worse? __Nothing __Lying Down __Standing __Walking __Sitting
__Movement __Exercise __Inactivity/Rest __Other_____

Can you perform your daily <u>home</u> activities? __Yes __Only with help __Not at all

Do you exercise? __Yes, almost daily __Yes, occasionally __Not at all

Describe your job requirements: __Mainly Sitting __Light Labor __Heavy Labor

Can you perform your daily <u>work</u> activities? __Yes __Only with help __Not at all

Describe your stress level: __None to mild __Moderate __High

Please list all allergies, including allergies to medications._____

List all medications you are presently taking, including vitamins and supplements. _____

_____

List any surgeries, fractures, serious illnesses or hospitalizations. _____

_____

Family Health History

Circle if a family member has had any of the following:

Cancer	Lupus	Heart Problems	High Blood Pressure	Epilepsy
Diabetes	Lung Problems	Chronic Back Problems	Rheumatoid Arthritis	Chronic Headaches

If circled any of the above conditions, please indicate all relations that apply:_____

_____

Social History *Indicate your use of the following: (L= Light, M= Moderate, H= Heavy)*

Alcohol	L M H	Tobacco	L M H	Drugs	L M H
Sugar	L M H	Salty Foods	L M H	Caffeine	L M H
Sleep	L M H	Exercise	L M H	Water	L M H

Past Health History Please check if you have experienced any of the following conditions at any point.

___Anorexia
___Arthritis
___Asthma
___Bladder Infection
___Blood Disorder
___Breast Lump
___Chronic Cough
___Chronic Sinusitis
___Colitis
___Convulsions
___Digestive Disorders
___Dizziness
___Epilepsy
___Fainting
___Headache
___Herniated Disk
___Jaw Pain
___Kidney Disorders
___Loss of Bladder Control
___Nervousness
___Pain-Neck
___Pain- Mid Back
___Pain- Low Back
___Pain- Arm/Elbow
___Pain-Hand
___Pain- Wrist
___Pain- Shoulder
___Pain- Ankle/Foot
___Pain-Leg
___Pain- Knee
___Rapid Heartbeat
___Rheumatic Fever
___Pregnancies
___Scoliosis
___Tinnitus (Ear Noise)
___Vision Disturbance
___Venereal Disease

Detailed Review of Systems

Cardiovascular: __N/A	**Now**	**Past**
Poor circulation	N	P
High Blood Pressure	N	P
Aortic Aneurysm	N	P
Heart Disease	N	P
Vascular Disease	N	P
Heart Attack	N	P
Chest Pain	N	P
High Cholesterol	N	P
Pace Maker	N	P
Jaw Pain	N	P
Irregular Heartbeat	N	P
Swelling of Legs	N	P
Stroke	N	P

Hematologic/Lymphatic: __N/A	**Now**	**Past**
Hepatitis	N	P
Blood Clots	N	P
Cancer	N	P
Easy Bruising	N	P
Easy Bleeding	N	P
Fevers/Chills/Sweats	N	P

Eyes: ___N/A	**Now**	**Past**
Glaucoma	N	P
Double Vision	N	P
Blurred Vision	N	P
Red/Itchy (allergy)	N	P

Genitourinary: __N/A	**Now**	**Past**
Kidney Disease	N	P
Lower Side Pain	N	P
Burning Urination	N	P
Frequent Urination	N	P
Blood in Urine	N	P
Kidney Stone	N	P
Bet Wetting/Enuresis	N	P
Prostate Problems	N	P

Gastrointestinal: __N/A	**Now**	**Past**
Acid Reflux	N	P
Bowel Problems	N	P
Constipation	N	P
Upset Stomach	N	P
Gas Pains	N	P
Ulcers	N	P
Gallbladder Prob.	N	P
Liver Prob.	N	P
Diarrhea	N	P
Nausea/Vomiting	N	P
Poor Appetite	N	P
Bloody Stools	N	P

Itegumentary: __N/A	**Now**	**Past**
Eczema	N	P
Rashes	N	P
Psoriasis	N	P
Skin Ulcers	N	P
Skin Disease	N	P

Respiratory: __N/A	**Now**	**Past**
Asthma	N	P
Shortness of Breath	N	P
Upper Respir. Infec.	N	P
Cold/flu	N	P
Pneumonia	N	P
Cough/Wheezing	N	P
Emphysema	N	P
RSV	N	P
Tuberculosis	N	P

Allergic/Immun.: __N/A	**Now**	**Past**
Autoimmune	N	P
Chronic Allergies	N	P
Seasonal Allergies	N	P
Food Allergies	N	P
Environmental Allerg.	N	P
Allergy Shots	N	P
Cortisone Use	N	P
HIV/AIDS	N	P
Hives	N	P

Endocrine: __N/A	**Now**	**Past**
Hyperthyroid	N	P
Hypothyroid	N	P
Type 1 Diabetes	N	P
Type 2 Diabetes	N	P
Hair Loss	N	P
Menopausal	N	P
Menstrual Prob.	N	P
Endometriosis	N	P
Hot Flashes	N	P

Ear/nose/throat: __N/A	**Now**	**Past**
Sinus Congestion	N	P
Sinus Infection	N	P
Nosebleed	N	P
Sore Throat	N	P
Difficulty Swallowing	N	P
Ear Ache	N	P
Ear Infections	N	P
Dizziness	N	P
Hearing Loss	N	P
Bleeding Gums	N	P

Musculoskeletal: __N/A	**Now**	**Past**
Poor Posture	N	P
Neck Pain	N	P
Back Pain	N	P
Arthritis	N	P
Rheumatoid Arth.	N	P
Joint Stiffness	N	P
Muscle Weakness	N	P
Osteoporosis	N	P
Broken Bones	N	P
Joint Replacement	N	P
Gout	N	P

Psychiatric: __N/A	**Now**	**Past**
Depression	N	P
Anxiety Disorder	N	P
Unusual Stress	N	P
OCD	N	P
Bipolar Disorder	N	P
SAD	N	P

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www.drphilwilkinson.com

Patient Acknowledgements

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been offered to me prior to my signing this Consent, and is readily available both in the clinic and if I ask. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice.
3. The practices "NOPP" is provided at the clinic, may also request a copy via fax, email, or mail.
4. The "NOPP" also describes my rights and the duties of this office with respect to my PHI.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. _____INITIAL

RELEASE OF INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, adjuster or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your health care facility _____ INITIAL

RIGHT TO RECEIVE PAYMENT

I authorize and sign to you, Dr. Wilkinson, to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay me any sums. I further authorize endorsements of my name to any draft containing my name to which you are legally entitled. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring full payment to our office immediately upon receipt. _____ INITIAL

VOLUNTARY TERMINATION OF CARE

I understand that if I suspend or terminate my care at any time, prior to Dr Wilkinson's recommended care, that my portion of all charges for professional services are immediately due and payable to Dr Wilkinson. All services performed by Dr Wilkinson will be directly charged to me, and ultimately I will be responsible for payment regardless of insurance coverage. _____INITIAL

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____ _____
Signature of Legal Representative Date Signed Relationship

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr Phillip H Wilkinson or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working for, or serving as back-up for Dr Phillip H Wilkinson, including those working at the clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of the office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____ Date:_____

Patient Signature:_____ OR Guardian Signature:_____

Financial Policy of
Wilkinson Clinic of Chiropractic

Explanation of Insurance Coverage: By signing below, you are stating that you understand that this office does not make any representations that your insurance provider will cover the cost of your care. Insurance policies vary greatly and it is your responsibility to check with your insurance provider regarding coverage for treatment *prior* to initiating the services of this clinic. Patient insurance is a contract between the patient and their insurance provider, not Wilkinson Clinic of Chiropractic or its employees. This office will do our best to file your insurance information and bill your insurance company in a timely manner. It is the further agreement between the undersigned and Wilkinson Clinic of Chiropractic as follows:

- It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether you have third party assistance with your financial obligation or are a self-pay patient. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.
- Unless agreed to in writing, all payment for treatments, deductibles, and co-payments are due at the time of service. If we participate in your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.
- Wilkinson Clinic of Chiropractic will make reasonable attempts to collect payment from your insurance provider on your behalf, but any unpaid balances will be your responsibility.
- If your insurance has not paid on an assigned bill within 30 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 90 days, the balance becomes due and payable immediately and your assignment is revoked.
- For your convenience, this office accepts cash, checks, and the following credit cards: Visa, MasterCard, American Express, and Discover.
- Should payment be refused by your bank for any check written, this office will charge a fee of $25 to offset the charges we will incur as a result of the returned check.
- Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.
- *This office does not turn away any patient due to their ability to pay. If you feel you might qualify for our financial hardship policy, notify the office immediately so we can begin your qualification process.*

Collection Notice: A penalty of 50% of the unpaid balance will be assessed against undersigned in addition to any balance due and owing if full payment is not received within 90 days of notice of balance due.

Waiver: That no assent, express or implied, by Wilkinson Clinic of Chiropractic, to any breach of any of the agreed upon terms, shall be deemed to be a waiver of any succeeding breach of the same covenant.

Default: If your account is more than 90 days past due, this office reserves the right to pursue any legal remedies at law or in equity and the prevailing party shall be entitled to collect reasonable attorney's fees and costs from the losing party.

Patient Name (Print): _____ Patient Signature: _____

Date: _____

Guardian Name (Print): _____ Guardian Signature: _____