PATIENT UPDATE FORM

Family Chiropractors
39 Watchung Plaza
Montclair, NJ 07042

NAME: _____ **DATE**: _____

ADDRESS (CITY, STATE, ZIP): _____

_____

HEIGHT _____ **WEIGHT** _____ **BLOOD PRESSURE** _____/_____

DATE OF BIRTH: _____ HOME PHONE #: _____

CELL PHONE #: _____ **EMAIL**: _____

INSURANCE COMPANY: _____

ID/PLAN #: _____

PRIMARY CARD HOLDER: _____ DOB: _____

***BRIEFLY DESCRIBE WHAT HAPPENED & CAUSE OF INJURY/SYMPTOMS:**

_____

_____

_____

1. HAVE YOU HAD SURGERY SINCE YOUR LAST VISIT? ☐ YES ☐ NO
   IF YES, DESCRIBE: _____

2. HAVE YOU EVER BEEN HOSPITALIZED (other than above surgeries) ? ☐ YES ☐ NO
   IF YES, WHY: _____
   _____

3. ARE YOU ALLERGIC TO ANY PRESCRIPTION MEDICATIONS? ☐ YES ☐ NO
   IF YES, PLEASE LIST MEDICATIONS AND SYMPTOMS: _____
   _____

4. **WHAT IS YOU CURRENT SMOKING STATUS:**
   ☐ Smoke Every Day ☐ Smoke Some Days ☐ Former Smoker ☐ Never Smoked

CONTINUE TO PAGE 2

5. HOW WOULD YOU RATE YOUR OVERALL HEATH:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

6. WHAT TYPE OF EXERCISE DO YOU DO:
☐ Strenuous ☐ Moderate ☐ Light ☐ None

7. HAVE YOU HAD SIGNIFICANT PAST TRAUMA? ☐ YES ☐ NO
IF YES, EXPLAIN: _____

_____

8. **INDICATE IF ANY FAMILY MEMBERS HAVE THE FOLLOWING (and what type, if applicable):**

☐ Rheumatoid Arthritis
☐ Heart Problems
☐ Diabetes: Type I or II _____
☐ Cancer: _____
☐ Lupus
☐ ALS
☐ OTHER: _____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past / Present	Past/ Present	Past / Present
☐ ☐ Headaches	☐ ☐ General Fatigue	☐ ☐ Ulcer
☐ ☐ Neck Pain	☐ ☐ Muscular Incoordination	☐ ☐ Hepatitis
☐ ☐ Upper Back Pain	☐ ☐ Visual Disturbances	☐ ☐ Gall Bladder Problems
☐ ☐ Mid Back Pain	☐ ☐ Dizziness	☐ ☐ Cancer
☐ ☐ Lower Back Pain	☐ ☐ **High Blood Pressure**	☐ ☐ Tumor
☐ ☐ Shoulder Pain	_____/_____(high point)	☐ ☐ **Asthma**
☐ ☐ Arm Pain	☐ ☐ Heart Attack	☐ ☐ Chronic Sinusitis
☐ ☐ Wrist Pain	☐ ☐ Chest Pains	☐ ☐ **Diabetes Type** _____
☐ ☐ Hand Pain	☐ ☐ Stroke	☐ ☐ Excessive Thirst
☐ ☐ Upper Leg Pain	☐ ☐ Angina	☐ ☐ Frequent Urination
☐ ☐ Hip Pain	☐ ☐ Kidney Stones	☐ ☐ **Tobacco Use**
☐ ☐ Knee Pain	☐ ☐ Kidney Disorder	☐ ☐ Drug/Alcohol Dependency
☐ ☐ Ankle/Foot Pain	☐ ☐ Bladder Infection	☐ ☐ Allergies
☐ ☐ Jaw Pain	☐ ☐ Painful Urination	☐ ☐ Depression
☐ ☐ Joint Swelling	☐ ☐ Loss of Bladder Control	☐ ☐ SLE
☐ ☐ Arthritis	☐ ☐ Prostate Problems	☐ ☐ Epilepsy
☐ ☐ Rheumatoid Arthritis	☐ ☐ Abnormal Weight Loss/Gain	☐ ☐ Dermatitis
	☐ ☐ Loss of Appetite	

Anything else pertinent to your visit today? _____

_____

_____

CONTINUE TO PAGE 3

9. **ARE YOU CURRENTLY TAKING ANY MEDICATIONS FOR ANY REASON?**

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued?**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

(October-March Only):

10. Have you had a flu shot this year?

□ Yes □ No □ I Will Be Getting One

If No, Why:

☐ I Had Bad Reaction in the Past

☐ I Got the Flu from the Shot

☐ I am Philosophically Opposed/ I Choose Not to Get One

PATIENT'S ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT FAMILY CHIROPRACTORS OF MONTCLAIR IS PERMITTED BY LAW, TO USE MY PERSONAL HEALTH INFORMATION, TO FACILITATE PAYMENT OF ANY FEES AND EXPENSES. FAMILY CHIROPRACTORS OF MONTCLAIR HAS AGREED TO ASSIST ME IN BILLING, MY HEALTH INSURANCE, AUTO INSURANCE AND ANY AND ALL OTHER APPLICABLE COLLATERAL SOURCES, AND ALTHOUGH THE PRACTICE WILL AWAIT THEIR DIRECT PAYMENT, I AGREE I AM FULLY AND PERSONALLY RESPONSIBLE, FOR ALL FEES I INCUR IN CONNECTION WITH SERVICE RENDERED FOR THE PURPOSE OF TODAY'S ENCOUNTER, AS WELL AS ANY FUTURE SERVICES, FOR ANY CONDITIONS, KNOWN OR AS OF YET UNKNOWN.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATE'S STATUTES.

Patient Signature_____ Date: _____

THANK YOU ! ☺

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MISSED APPOINTMENT AND CANCELLATION POLICY

Family Chiropractors of Montclair are committed to providing exceptional care.

Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (973)783-5666 within 24 hours of your scheduled appointment to notify us of any changes or cancellations.

If prior notification is not given, you will be charged your copay for the missed appointment.

To help insure you don't miss your appointment, we are happy to set up appointment reminder texts and provide appointment reminder cards.

We look forward to better serving you!

Family Chiropractors
39 Watchung Plaza
Montclair, NJ 07042
(973) 783-5666

Health Insurance Financial Policy

Since most health insurance plans have a deductible, you must pay 100% of your charges until your deductible is satisfied. Once you have met your deductible, we will accept authorization for direct payment of benefits to this office. You must provide us a copy of your health insurance card.

Upon receipt of this information, we will contact your company to verify the eligibility of chiropractic benefits. All information provided to us by your insurance company included any policy limitations or exclusions will be discussed with you. Since most health insurance plans do not reimburse health care expenses 100%, you may be responsible for your co-payment/co-insurance. CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Patients selecting this option understand this office submits bills and awaits direct payment from insurance companies as a courtesy, and that in no way relieves patients of their financial responsibility to this office. If your insurance company denies or delays reimbursement to this office for any reason, the allowable expenses are your responsibility. MONITORING ANY POLICY LIMITATIONS IS CONSIDERED THE RESPONSIBILITY OF THE PATIENT.

I authorize all insurance companies, third party payers and attorney's to make direct payment of my benefits to Family Chiropractors of Montclair for all monies due to my account for the services I have received. If my policy prohibits assignment, I direct my insurance company to mail all checks made payable to me, directly to Family Chiropractors of Montclair at 39 Watchung Plaza, Montclair, NJ 07042.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date