

Arapahoe Chiropractic & Acupuncture Center

1

Patient Information

Date _____

Patient Name _____
Last

_____ First _____ Middle Initial

Address _____
Street

_____ City _____ State _____ Zip

Email _____

Date of Birth _____ SSN _____

Sex Male Female

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Occupation _____

Company or School Name _____

Address _____
Street

_____ City _____ State _____ Zip

Phone _____

Spouse's Name _____

Date of Birth _____ SSN _____

Employer _____

Whom may we thank for referring you? _____

2

Insurance Information

Subscriber's Name _____

Relationship to Patient _____

Date of Birth _____

Insurance Company _____

Group Number _____ Identification Number _____

Is patient covered by additional insurance? Yes No

If Yes, Subscriber's Name _____

Date of Birth _____ Relationship to Patient _____

Insurance Company _____

Group Number _____ Identification Number _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient

3

Phone Numbers

Cell Phone _____ Home Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4

Accident Information

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of the accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

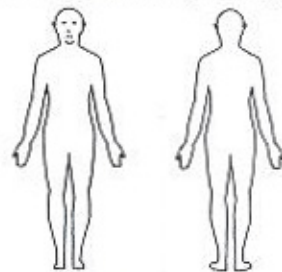
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Mark an X on the diagram where you have symptoms.



What treatment have you already received for your condition?

- Medications
 Surgery
 Physical Therapy
 Chiropractic Services
 No Treatment
 Other Treatment _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Urine Test _____ MRI, CT-Scan, Bone Scan _____

Indicate if you have had any of the following: (Check all appropriate boxes)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychological Care |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |

Other _____

Exercise

- None
 Moderate
 Daily
 Heavy

Work Activity

- Sitting
 Standing
 Light Labor
 Heavy Labor

Habits

- Smoking *Packs per Day* _____
 Alcohol *Drinks per Week* _____
 Coffee/Caffeine Drinks *Cups per Day* _____
 High Stress Level *Reason* _____

Pregnant? *Due Date* _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins, Herbs, Minerals

Pharmacy Name _____
 Pharmacy Phone _____

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

PICA MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER PICA

1. (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS
Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT? PLACE (State) YES NO
c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. OTHER INSURED'S POLICY OR GROUP NUMBER

13. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

14. EMPLOYER'S NAME OR SCHOOL NAME

15. INSURED'S DATE OF BIRTH MM DD YY SEX M F

16. EMPLOYER'S NAME OR SCHOOL NAME

17. INSURANCE PLAN NAME OR PROGRAM NAME

18. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (M.P.) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO

23. PRIOR AUTHORIZATION NUMBER

24	A		B		C	D		E	F	G	H	I	J	K
	From	To	Place of Service	Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT, HCPCS, MODIFIER	DIAGNOSIS CODE							
1														
2														
3														
4														
5														
6														

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE PIN# GRP#