anew

Chiropractic • Acupuncture • Massage • Sports

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ SEX CIRCLE M or F

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

EMAIL _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____

RELATIONSHIP _____ PHONE _____

HOW DID YOU HEAR ABOUT US? _____

ANEW CHIROPRACTIC SPORTS CENTER does not process insurance claims but will provide receipts for services rendered. All payments shall be made on the day of service.

I understand that I am responsible for any amount due for services rendered. Furthermore, I give consent to be treated by the physicians/staff at ANEW CHIROPRACTIC SPORTS CENTER.

SIGNATURE _____ DATE _____

☐ Yes, I would like to receive emails about events at Anew.

☐ No, I do not want to receive emails about events at Anew.

HEALTH HISTORY

NAME:_____ DATE:_____/____/_____

DATE OF BIRTH: _____/_____/_____

Have you ever had any of the following?

	Self	Mother	Father	Sibling
Diabetes				
High Cholesterol				
High Blood Pressure				
Heart Trouble				
Stroke				
Kidney or Urinary Disorder				
Bowel GI Disorder				
Bleeding or Blood Disorder				
Asthma or Emphysema				
Cancer				
Glaucoma or Eye Problems				
Neurological Disorder				
Mental Illness				
Thyroid Problem				
Arthritis				
Sexually Transmitted Disease				
Hepatitis or Yellow Jaundice				
Chicken Pox				
Blood Transfusion				
Infectious Disease				
Other				

List Current Medication & Dose

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies

_____
_____
_____
_____

Hospitalization or Surgeries and the Year

_____
_____
_____
_____
_____

Do you smoke or use oral tobacco? _____
How much_____ How Long_____

Do you drink alcohol _____
How much_____ How Long_____

Have you ever experimented with drugs?_____

For Women Only

Are you Pregnant? _____
Last Menstrual Period _____
Number of Pregnancies_____
Last Pap smear _____
Last Mammogram_____

DR. SIGNATURE_____

CHIROPRACTIC HISTORY

Patient Name _____ D.O.B. _____

WHERE is your pain today? (Please circle) NECK UPPER BACK HIP ANKLE

SHOULDER LOWER BACK KNEE OTHER _____

WHEN did this pain begin? ____/____/_____
Have you had a history of this pain or any similar pain? YES NO
If yes, explain _____
WHAT were you doing when this pain began? (Please Explain)

_____

_____

Have you seen another doctor(s) for your current pain? YES NO
If yes, who _____
Are you currently taking medication for this pain? YES NO
If yes, list. _____
Have you had an X-Ray or MRI? YES NO
X-RAY Date: _____ MRI Date:_____ Other:_____
What makes this pain WORSE?

_____

_____

What makes this pain BETTER?

_____

_____

DESCRIBE your pain (Please circle & explain)
DULL/ACHY SHARP THROBBING STABBING NUMB/TINGLE TIGHT OTHER
EXPLAIN: _____
Rate your pain (Please circle 0-10)
0 1 2 3 4 5 6 7 8 9 10
NO PAIN SOME PAIN PAIN AFFECTS LIVING ER
How often do you feel this pain? (Please circle percentage)
0 10 20 30 40 50 60 70 80 90 100
When is the pain worse? (Please circle)
MORNING NIGHTTIME PROGRESSIVELY WORSE AS THE DAY GOES ON

DAYTIME SLEEP
Do you exercise? YES NO
If yes, how often and how much?
_____days/week _____minutes/day

Do you smoke? YES NO
If Yes, How much?____pks/day

Dr Signature_____Date____/_____/____

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Office and Financial Policies

Eric J. LeBouef, DC, CCSP Yael Gurwitz-Elkin, DC

Welcome and thank you for choosing Anew Chiropractic for your care. We are committed to providing you with the highest quality care in an efficient, timely, and cost-effective manner. We hope that providing you with our policies in advance we can prevent any misunderstanding at the time of your visit.

Initials: ____ **Check-In: Please arrive about 15 minutes before your scheduled appointment time, so that all paperwork may be completed before you see the provider.** Payment is due at time of checkout. **Check-Out: Please be prepared to pay for the current visit as well as any past balances on your account.** For your convenience, we take cash, check, or credit cards.

Initials: ____ **Late Arrivals: We do our best to keep the schedule**. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes late you may be asked to reschedule your appointment so that other patients are not inconvenienced.

Initials: ____ **Dishonored Checks: A $30 service fee will be assessed on all dishonored checks**. The full amount of the check written plus $30 must be paid by cash or credit card. If payment is not received within 10-15 business days your information will be filed with the Montgomery County Hot Check Division. We will be unable to see you until payment is made in full. If you have 2 occurrences we will no longer be able to accept a check from you.

Initials:____ **Financial Policy: If you are a self paying patient, please consult the front desk coordinator to get an estimate of charges.** Prompt pay discount is only given when the balance is paid in full the same day of service.

Initials:____ **No Show/Short Notice Cancellation Acknowledgement:** We at Anew Chiropractic strive to provide our patients with the best care and quickest appointment times possible. Unfortunately there are patients who make appointments but do not keep them or cancel their appointments with short notice. This is very disruptive from a business perspective; therefore, Anew Chiropractic has now instituted a policy of charging patients $35 if a patient NO SHOWS or cancels an hour massage appointment later than 3:00 pm the business day prior to the appointment. The fee is $25 for a 30 minute massage appointment. The charge will be placed on the patient's account and a future appointment will only be made if there is a credit card on file. Anew Chiropractic hopes you understand this policy was instituted with much thought. This is in no way takes away from the respect Anew Chiropractic has for all of our patients who give appropriate notice if they are unable to appear for a scheduled massage appointment.

By signing this form, you are acknowledging that you will be billed every time you NO SHOW for a massage appointment or if you fail to cancel prior to 3:00 p.m. the business day before your appointment.

I have read, understand, and agree to the above office and financial policies. I herby attest that I have given and agree to provide accurate demographic and health related information.

Patient Name: _____ DOB: _____

Signature : _____ Date: _____

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Health Disclosure Information

I, _____ will allow Anew Chiropractic to disclose information to the following person(s) about my health, if I am not available.

Acknowledgement of review of Notice of Privacy Practices

I can be offered a copy to review of Anew Chiropractic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. Please ask for your copy at time of check in if desired.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient or Personal Representative Date

Consent to Treat Minors

I hereby authorize Dr. Eric LeBouef and/or Dr. Yael Gurwitz or whoever else he/she designates to administer treatment as he/she deems necessary to my:

Son Daughter Other _____

_____ _____

Print Name of Patient Date

_____

Print Name of Guardian Signature of Guardian

_____

Print Name of Witness Signature of Witness