Baxter Village Health Center

New Patient Information

(To be completed by all new patients receiving Chiropractic, K-Laser, Reflexology, Acupuncture, Massage Therapy, and Physical Therapy)

Patient Data

Name: _____ DOB: _____/_____/_____
First Middle Initial Last MM DD YYYY

Address: _____

City: _____ State: _____ Zip: _____

Sex: Male/Female Social Security #:_____-_____-_____

Marital Status: Single Married Divorced Widow Other: _____

Home #: (_____)_____-_____ Cell #:(_____)_____-_____

Work #:(_____)_____-_____ Email Address: _____

May we contact you via email? Y/N

Emergency Contact: _____ Phone: (_____)_____-_____

Referral Information

(How did you hear about us OR who referred you to us?)

Friend/Family: _____	Lotus Pilates & BodyWorks	Community Event
May we contact them to say "thank you" for referring you? Y or N	Internet Search	Social Media
Physician: _____	Print Advertising	Word of Mouth
May we contact them to say "thank you" for referring you? Y or N	Other: _____	

Insurance Information

(Not all services rendered are covered by insurance)

Policy holder: _____ DOB:_____/_____/_____

Insurance Company: _____Phone: (_____)_____-_____

Subscriber ID #: _____ Group #:_____

Name of Insured: _____ DOB: _____/_____/_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibilities for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I also acknowledge it is my responsibility to obtain all referrals my insurance may require (ie. many insurance companies require a referral from a physician to continue seeing a physical therapist 30 days after the initial visit).

Patients's Signature: _____ Date: ____/____/_____
(Parent or Guardian if patient is a minor)

Baxter Village Health Center

Insurance Assignment

Must be signed by all who wish to go through insurance now or in the future.

I, _____, request, authorize and further direct that any insurance company which is liable for reimbursement for services rendered make payments directly to you, I request payment of government or medical benefits to the undersigned physician's office below. I further authorize and give my permission for you to endorse checks, drafts and payments received in my behalf for medical services rendered. It is further understood that if any point the monies received exceed my indebtedness, these funds will be returned to me by your office and it is my responsibility to comply with any subrogation clause which may be contained in my medical insurance.

I herby assign and transfer to you any cause of action that exists in my favor against such company and authorize you to prosecute said actions, either in my name or your name, as you see fit. It is agreed, however that in transferring this cause of action it is agreed between all parties that your interest in this case shall be limited to the amount of medical bills rendered to me by you and your appointee. It is further understood and agreed by all parties that the transfer of this cause shall be limited to medical bills rendered on my behalf and that are related only to the case in question. For the above named purpose, I further authorize and transfer to you my limited power of attorney so that you may act in my behalf in this regard, and this regard only. It is agreed that you will make all reasonable efforts to collect sums due from the insurance carriers with a liability in this case; however, it is my ultimate responsibility to pay in full for all services rendered to me.

I herby state and agree to this authorization and assignment may not be withdrawn unilaterally.

Patient Name: _____ Date: _____

Patient's Signature: _____
(Parent or Guardian if patient is a minor)

Witness Signature: _____

Cancellation Policy

(To be completed by all new patients receiving Chiropractic, K-Laser, Reflexology, Acupuncture, Massage Therapy, and Nutritional Therapy)

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.
Office appointments which are cancelled with less than 24 hours notification may be subject to cancellation fee of 50% of the full cost of the originally schedule service, (i.e a 60 minute massage is $75 therefore cancellation fee would be $37.50).

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management and provider approval.

Patient Name: _____ Date: _____

Patient's Signature: _____
(Parent or Guardian if patient is a minor)

Witness Signature: _____

If you feel inspired to leave your massage therapist or reflexologist a tip, please inform the front desk prior to running your credit card as we do not have a "tip line" available on your receipt. Thank you!

1171 Market Street, Suite #112 Fort Mill, SC 29708

Medical/Health History

(To be completed by all new patients receiving Chiropractic, K-Laser, Reflexology, Acupuncture, and Massage Therapy)

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems may affect your overall course of care. Please circle if you are currently experiencing or have a history of the following:

Alcoholism	Allergies	Anemia	Arteriosclerosis	Dental Concerns
Arthritis	Asthma	Back Pain	Paralysis	Autoimmune Disease(s)
Bronchitis	Bruise Easily	Cancer	Chest Pain/Condition	Hearing Difficulties
Cold Extremities	Constipation	Cramps	Depression	Bladder Difficulties
Diabetes	Digestive Problems	Dizziness	Ear Ringing	TMJ/TMD
Emphysema	Epilepsy	Gout	Heart Disease	Sexual Dysfunction
Excessive Menstruation	Eye Pain/Difficulties	Fatique	Frequent Urination	Infertility Concerns
Headaches	Hemorrhoids	High Blood Pressure	Hot Flashes	Whooping Cough
Hepatitis A, B, or C	Hypoglycemia	Injuries	Intestinal Parasites	Chicken Pox
Irregular Heart Beat	Irregular Cycle	Kidney Infection	Kidney Stones	Poor/Excessive Appetite
Loss of Memory	Loss of Balance	Loss of Smell	Loss of Taste	Anxiety
Low Blood Pressure	Appendicitis	Bleeding Disorder	Emotional Difficulties	Dry Mouth
Multiple Sclerosis	Mumps	Pacemaker	Weight Loss/Gain	Women:
Neck Pain/Stiffness	Nervousness	Nosebleeds	Poor/Excessive Thirst	Date of last menses?
Polio	Poor Posture	Prostate Difficulties	Sciatica	Are you pregnant?
Scarlet Fever	Surgery	Ulcer	Vision Problems	If so, due date:
Shortness of Breath	Sinus Infection	Sleep Problem or Insomnia	Spinal Curvature	# of Pregnancies:
Stroke	Swelling of Ankles	Swollen Joints	Thyroid Condition	____ births _____ miscarriages
Tuberculosis	Ulcers	Varicose Veins	Venereal Disease	Type and date of delivery(ies):

Other: _____

If you answered yes to any of the above please explain: _____

_____

Have you ever been hospitalized? _____ If so, please list the reason: _____

Caffeine _____X per day OR week
Tobacco _____X per day OR week
Drugs _____X per day OR week
Water _____X per day OR week
Artificial Sweeteners _____X per day OR week

Refined Sugar _____X per day OR week
Alcohol _____X per day OR week
Soft Drinks _____X per day OR week
Exercise _____X per day OR week

List of current medications and/or supplements (include dosage if known): _____

_____

I have provided correct and complete information to the best of my knowledge and understand it is my responsibility to update my provider in the event there are any changes.

Patient's/Guardian's Signature: _____ Date: _____

Acupuncture
Review of Systems

Please fill this out carefully, even if some of the symptoms do not seem at all connected to your current issue. If you are currently experiencing the symptom circle it, if you have experienced it in the past, please put a check by it.

Head/Face:	**Eyes:**	**Nose:**	**Mouth:**
Headaches	Blurry Vision	Frequent Colds	Dental Problems
Dizziness	Eyelid Twitching	Sinus Trouble	Periodontal Problems
Memory Loss	Floaters	Bleeding	TMJ/TMD/Grinding
Other	Pain		Unusual Taste
			Other
Throat:	**Respiration:**	**Heart/Chest:**	
Sore Throat	Difficulty Inhaling	High Blood Pressure	**Circulation:**
Hoarseness	Difficulty Exhaling	Low Blood Pressure	Easy Bruising
Difficulty Swallowing	Pain	Chest pain	Easy Bleeding
Dryness	Congestion	Chest Tightness	Cold Limbs-Hands or Feet
Other	Shortness of Breath	Difficulty Lying Down	Reynaud's Syndrome
	Other	Other	
Gastrointestinal:			**Neurological:**
Always Thirsty	**Urination:**	**Skin:**	Nervousness/Anxiety
Never Thirsty	Frequent	Acne	Tremors
Excessive Appetite	Difficult	Dryness	Numbness or Tingling
Low Appetite	Painful	Moles that change	Lack of Coordination
Gas/Bloating	Nocturnal	Lumps	Nerve Pain
Stomach or Abdominal Pain	Bleeding	Excessive Sweating	Other
Nausea	Other	Night Sweats	
Diarrhea/Loose Stools		Rarely Sweats	**Pain:** Please Explain
Constipation	**Sleep:**	Other	
Rectal Bleeding	Insomnia		
Colon Problems	Drowsiness	**Any other concerns:**	
	Excessive Dreaming		
	Walking Easily		
	Other		

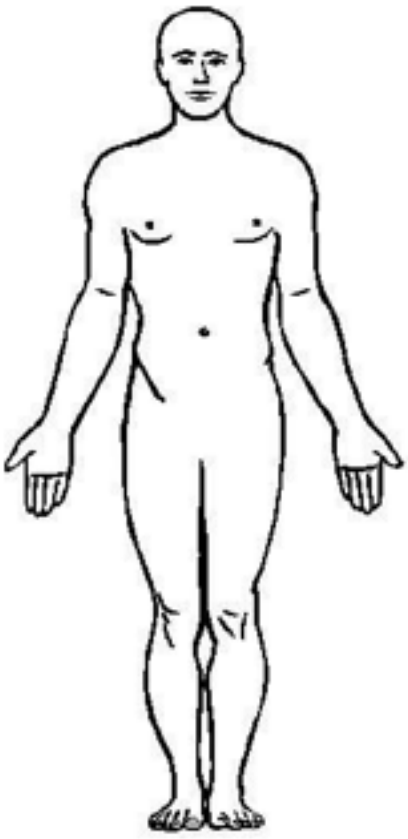
I have provided correct and complete information to the best of my knowledge and understand it is my responsibility to update my provider in the event there are any changes.
Patient's Guardian's Signature: _____ Date: _____

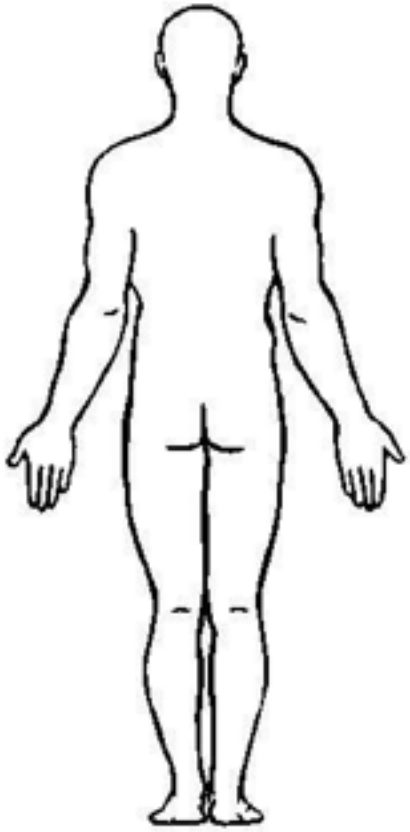
Baxter Village Health Center

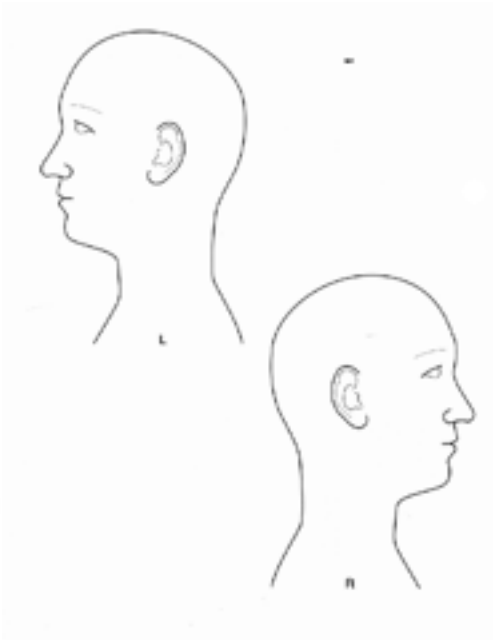
Diagram Of Concern

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A= Ache	O= Other
B= Burning	P= Pins & Needles
N= Numbness	S= Stabbing







Baxter Village Health Center

Chief Complaint-Chiropractic Care

Have you seen a chiropractor before? No Yes

Date of last physical exam: _____/_____/_____

Reason for consulting this office (please check all that apply)

O Pain	O Optimal Health	O Auto Accident	O Pregnancy
O Sports Injury Date of Injury: _____	O Auto Injury Date of Injury: _____	O Personal Injury Date of Injury: _____	O Other: _____

Date symptoms appeared: _____/_____/_____

Describe your symptoms: _____

Describe the pain:

O Deep	O Superficial	O Dull	O Sharp	O Burning	O Other
O Achy	O Throbbing	O Stabbing	O Shooting	O Boring	

List of other health care provider(s) you have seen for this injury/complaint.

_____

What was their diagnosis? _____

Have you had x-rays/MRI/CT on area: No Yes If yes, explain: _____

What percent of the day do you have pain? __ 0-25% __ 26-50% __ 51-75% __ 76-100%

When do you feel your best? __ morning __ afternoon __ evening

When do you feel your worst? __ morning __ afternoon __ evening

Have you had injuries in the past? *Include all auto accidents, falls, sports trauma, etc and dates:*

_____

Have you ever broken any bones? No Yes If yes, describe and give date: _____

I have provided correct and complete information the best of my knowledge and understand it is my responsibility to update my provider in the event there are any changes.

Patient's/Guardian's Signature: _____ Date: _____