Celanese Chiropractic Health & Performance
Dr. Clay Gasparovich

1924 Mt Gallant Rd
Rock Hill, SC 29732
P: (803) 323-5500

PATIENT INFORMATION

Full Name _____ Birth Date _____ Gender M F
Address _____ SS# _____ - _____ - _____ Work Phone _____
City _____ State ____ Zip _____ Cell Phone _____ ____
In order to receive text reminders, please provide phone carrier (AT&T, Verizon, etc.) _____

Marital Status S M W D Sep / Spouse Name _____ Birth Date _____
Are you a student? Y N / Full-time Part-time
Your Employer _____ Your Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Spouse's Employer _____ Spouse's Occupation _____

INSURANCE (Please allow our staff to photocopy your current license & health insurance card (s)).

Email: _____ **Referred by:** _____

Family History

Please take a few moments to complete the following. The better you fill out, the better it will help us to treat your condition. Thanks for your cooperation.

Place an "X" in any box that may apply.

	Mother	Father	Brother	Sister	Children	Spouse
Back Pain						
Neck Pain						
Headaches						
Pinched Nerve						
Scoliosis						
Arthritis						
Numbness						
Cold Hands/Feet						
Carpal Tunnel						
Sport Injuries						

- I authorize payment of medical benefits to this office
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the notice of privacy practices of this office. (Once information is disclosed, it may not be protected by law.)

Patient's Signature _____ Date _____
Spouse's or Guardian's Signature _____ Date _____
(Authorization expires 3 years from date above)

CASE HISTORY

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaints.

1. _____ How long?_____
2. _____ How long?_____
3. _____ How long?_____
4. _____ How long?_____

Is your condition(s) related to an accident? ☐YES ☐ NO

Date of accident: _____ State: _____ Type of Accident: ☐Auto ☐Work Related ☐Other_____

What words would best describe your condition(s)? (ex. ache, burn)_____

Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe)

0 1 2 3 4 5 6 7 8 9 10

When is your condition most severe? _____

When is your condition least severe? _____

What makes your condition feel worse? _____

What makes your condition feel better? _____

What activities are difficult because of your condition(s)? _____

Have you seen any other health care provider for your present condition? ☐ Yes ☐ No

Who? _____

Current Medications_____

Are you or could you be pregnant? ☐YES ☐ NO

Are you experiencing or do you have any of the following?

☐ A sore that won't heal
☐ Any bleeding/discharge
☐ Bladder/ bowel problems
☐ Difficulty swallowing
☐ Lump/thickening anywhere
☐ Night pain
☐ Persistent cough/hoarseness
☐ Wart/mole changes
☐ Weight loss without trying
☐ **None of the above**

Review of Systems

In addition to the symptom(s)/dysfunctions(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

☐ Anxiety
☐ Atrophy
☐ Concussion
☐ Depression
☐ Difficulty walking
☐ Dizziness
☐ Extremity deformity
☐ Facial drooping
☐ Headache
☐ Joint deformity
☐ Joint locking
☐ Joint swelling
☐ Lack of coordination
☐ Limited range of motion
☐ Loss of balance
☐ Memory loss
☐ Mood swings
☐ Muscle weakness
☐ Numbness
☐ Popping noises
☐ Psychiatric disorders
☐ Seizures
☐ Sensory changes
☐ Speech problems
☐ Stiffness
☐ Tremors
☐ Twitches
☐ Vision trouble
☐ **None of the above**

Cardiovascular System

☐ Ankle Swelling
☐ Blood Clots
☐ Carotid blockage
☐ Changes in skin color
☐ Chest Pain
☐ Dizziness
☐ Fainting
☐ Hypertension
☐ Jaw pain
☐ Known vascular
☐ Mitral valve prolapse
☐ Phlebitis
☐ Pin stroke
☐ Previous stroke
☐ Shortness of breath
☐ Varicose veins
☐ **None of the above**

Past History

List any surgeries you have had (including appendix, tonsils, wisdom teeth, etc.)

1._____ Date _____
2._____ Date _____
3._____ Date _____
4._____ Date _____

Have you ever been hospitalized for anything in addition to surgeries? ☐ YES ☐ NO

If so, when and for what reason? _____

Have you ever been diagnosed as having a particular condition? (Diabetes, heart trouble, cancer)

☐YES ☐ NO _____

Are you currently under a doctor's care for conditions other than the ones you are seeking care for?

☐YES ☐ NO _____

Patient Billing Acknowledgement Form
Non-Covered Services

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. This may include items such as vitamins or certain chiropractic supplies.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

Non-covered services may include but not limited to:

Procedures	**Reason**
Taping	Insurance does not cover
Interferential Current	
Mechanical Traction	
Ice Compression	
Pneumatic Compression Sleeves	
Maintenance	
Supplements/Supplies	
Orthotics	
Therapeutic Massage	

Patient

I _____, acknowledge that I have been told in advance by my provider
Name-please print

that the services/products listed above are not covered by my health plan. I agree to pay for these non-covered services.

SEE BACK...

Celanese Chiropractic Health & Performance
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At Celanese Chiropractic Health & Performance our major concern is to assist you in maintaining overall good health. However, we feel it is our responsibility to let you know that your insurance is only responsible for those visits necessary to return you to your symptomatic improvement.

Once we have reduced your symptoms your insurance may no longer be responsible for payment of any additional care.

Since often it is beneficial for the patient to continue supportive care, we like to inform you in advance that you may be financially responsible.

I have read and understand the above information:

_____ _____
Patient/Guardian Signature Date

RELEASE AND ASSIGNMENT

TO MY INSURANCE CARRIER:

1. I authorize the release of any information necessary to process my insurance claims.
2. I authorize and request payment of medical benefits directly to my physician named below:

Celanese Chiropractic Health & Performance
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3. I agree this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that a photocopy of this document may be used in lieu of the original.

Patient Name:_____

_____ _____
Patient/Guardian Signature Date

CELANESE CHIROPRACTIC HEALTH & PERFORMANCE

AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released you must sign this form. Signing this form will only give consent to release this information to the individuals indicated below. This consent form will not allow Celanese Chiropractic Health & Performance to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow Celanese Chiropractic Health & Performance to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

Patient Name:_____

Patient Signature:_____ Date:_____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Occasionally it is necessary for the staff of Celanese Chiropractic Health & Performance to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Celanese Chiropractic Health & Performance discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name:_____

Patient Signature:_____ Date:_____

*For Office Use Only: Patient ID*_____

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