

WELCOME TO ZIVKOVIC CHIROPRACTIC CENTER

DATE: _____

Please print clearly and fill in completely.

ABOUT YOU:

Patient Name: _____ Email: _____ Male Female

What do you prefer to be called: _____ SS# _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth: _____ Age: _____ Who referred you to us? _____

Phone #: Home _____ Work _____ Cell _____

Status: minor single married divorced separated widowed

Employer: _____ How long? _____ Occupation: _____

Spouses name: _____ Do you have children? yes no How many? _____

HISTORY:

Reason for seeking chiropractic care: _____

Describe any health problems, including how long you have had them:

Describe the pain and it's location: _____

When did condition begin? ___/___/___

Is the condition getting worse? yes no constant comes and goes

Is this condition interfering with your (circle) work, sleep or daily routine.

Explain _____

Have you had the same or similar conditions in the past? yes no

Explain _____

Have you been treated by a medical physician for this condition? yes no Where _____

CHIROPRACTIC HISTORY:

Have you ever been to a chiropractor before? yes no If yes, doctor's name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? yes no Who? _____

WELLNESS COMMITMENT:

At this chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100% please circle your personal level of commitment toward obtaining and maintaining wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

For Females: Are you taking birth control? yes no

Are you Pregnant? yes no / How far long? _____ Nursing? yes no

IN EVENT OF EMERGENCY:

Contact: _____ Relation: _____

Home phone: _____ Work or Cell phone: _____

HEALTH HISTORY:

Current Weight _____ lbs. Current Height _____ ft. _____ in.

Are you taking any of the following medications?

- Nerve pills pain killers muscle relaxers stimulants blood thinners insulin tranquilizers other(s) _____

Do you have or have you had any of the following?

- Y N Heart Attack/Stroke Y N Heart Surg/Pacemaker Y N Heart Murmur
Y N Congenital Heart Defect Y N Mitral Valve Prolapse Y N Artificial Valves
Y N Alcohol/ Drug Abuse Y N Venereal Disease Y N Hepatitis
Y N HIV+/Aids Y N Shingles Y N Cancer
Y N Frequent Neck Pain Y N Emphysema/ Glaucoma Y N Anemia
Y N High/Low Blood Pressure Y N Psychiatric Problems Y N Rheumatic Fever
Y N Frequent Headaches Y N Kidney Problems Y N Ulcers/ Colitis
Y N Seizures/Epilepsy Y N Sinus Problems Y N Asthma
Y N Diabetes/ Tuberculosis Y N Difficulty Breathing Y N Chemotherapy
Y N Lower Back Problems Y N Artificial Bones/ Joints Y N Arthritis
Y N Fainting Y N Insomnia Y N Digestive Problems

Please list any other serious medical condition (s) you have or ever had: _____

List anything you may be allergic to: _____

List previous surgeries/ treatments with dates: _____

List any past accidents with dates: _____

List any x-rays you have had in the past 2 years: _____

Family Health History: _____

Do you take supplements or vitamins? yes no Exercise yes no special diet? yes no

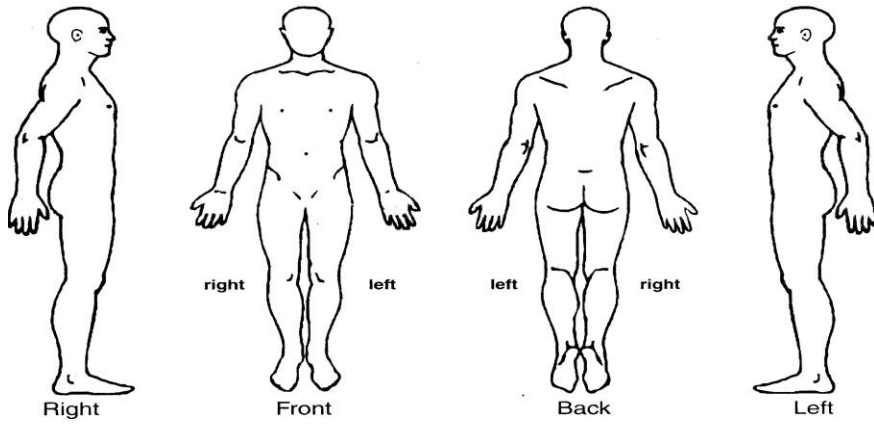
Do you smoke yes no How much? _____ How long? _____ How old is your mattress? _____

Is it comfortable? yes no Do you wear Heel Lifts Sole Lifts Inner soles Arch supports

SHOW US WHERE IT HURTS:

Mark areas of injury or discomfort with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Table with 6 columns: Description- Numbness, Pins & Needles, Burning, Aching, Stabbing; Symbol- NNNN, PPPP, BBBB, AAAA, SSSS



INSURANCE INFORMATION: Insurance Company name: _____
 Address _____ Phone# _____
 InsuredSS# _____ ID# _____ Group# _____
 Insured's Name: _____ Relation: _____
 Insured's Date of Birth: ____/____/____ Insured's Employer _____

ACCOUNT INFORMATION: Person ultimately responsible for account
 Name: _____ Relation: _____
 Billing Address: _____
 SS#: _____ D.L. # _____
 Work Phone# _____ Cell Phone# _____

Payment Method: CASH CHECK CREDIT CARD

_____ (initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

- ❖ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.
- ❖ Our office policy requires payment in full for all services rendered at the time of visit, unless prior arrangements have been made with the office manager. If account is not paid within 90 days from the date of service and no arrangements have been made, I understand I am responsible for legal fees, collection agency fees and any other expenses incurred in collecting my account .
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information that I have provided.

Signature _____ Date ____/____/____

If patient is under the age of 18 this portion needs to be filled out
CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Zivkovic and whomever he/she may designate as assistant to administer treatment as he/she so deems necessary to my son/ daughter, _____
 Date: _____

Parent/ Guardian- Print & Sign: _____

Witness/ Office staff: _____

ZIVKOVIC CHIROPRACTIC CENTER
DR. ANNETTE ZIVKOVIC DR. ROBERT ZIVKOVIC
We're Working Together For Your Health.

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in extremely rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain strain injuries, irritation of a disc condition, and, rarely, fractures. One of the rarest complications associated with chiropractic care—occurring at a rate between one instance per one million to one instance per two million—is the instance of cervical spine (neck) adjustments being applied to a pre-existing vertebral artery injury that could result in stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessments.

Patient Name (Printed) _____ Date _____

Patient or Legal Guardian Signature _____ Relationship to Patient _____

Witness Signature (Office Staff) _____ Date _____

*******FINANCIAL POLICY*******

OUR OFFICE POLICY IS THAT FEES ARE DUE WHEN SERVICES ARE RENDERED

PLEASE INITIAL LINES 1-5 AND SIGN THE BOTTOM AFTER YOU HAVE READ AND UNDERSTAND THEM ALL.

We will gladly discuss the cost of your visit and do our best to answer any questions related to payments or insurance. However, you must realize that:

1. _____ If you have any insurance that you would like us to file, you must provide the benefit information and any forms to the receptionist prior to treatment. Please check with the receptionist to assure that we are contracted providers for your insurance.
2. _____ If you choose to use any form of insurance, you will be responsible for any claims that are not paid within 90 days. **WE DO NOT FILE SECONDARY INSURANCE.** We will be happy to run a receipt of each visit for you to send to your secondary insurance.
3. _____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
4. _____ I do hereby agree to pay for any treatment at the time of visit and that I will be held responsible for the balance of my account.
5. _____ I understand the methods of payment accepted are credit cards, checks and cash. If payment is returned for insufficient funds, a fee of \$ 25.00 will be charged.

Signature: _____ Date: _____

WE MUST EMPHASIZE AS YOUR HEALTH CARE PROVIDER, OUR RELATIONSHIP AND CONCERN IS WITH YOU AND YOUR HEALTH, NOT YOUR INSURANCE COMPANY.

ZIVKOVIC CHIROPRACTIC CENTER
DR. ANNETTE ZIVKOVIC DR. ROBERT ZIVKOVIC

We're Working Together For Your Health

DOCTOR/ PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC:

It is important to recognize the difference between chiropractic and medicine. Either can be important to your health, but for entirely different reasons. Chiropractors seek to restore health through natural means and without the use of medicine or surgery. Although a medical diagnosis may be of great importance to a patient, such diagnosis does not necessarily assist the chiropractor in his efforts. The chiropractor's purpose is to restore health through the natural flow of energy in the nervous system. This gives the body maximum opportunity to heal itself. The success of the Chiropractic procedures often depends upon underlying causes and conditions. It is important to understand what to expect from chiropractic and medical services in order that you, the patient, can determine whether either or both may be of benefit to you.

ANALYSIS:

A chiropractor conducts a chiropractic analysis for the express purpose of determining whether there is evidence of spinal subluxation. When such subluxations are found, Chiropractic adjustments are given to restore spinal alignment. It is the chiropractor's premise that proper spinal alignments allows free nerve flow throughout the body and gives the body its best chance to restore health. Due to the complexities of nature, no chiropractor can promise you specific results. This depends upon the recuperative powers of the body.

DIAGNOSIS:

Although chiropractors are experts in chiropractic analysis, they are not specialists in the field of diagnosis. Internists are medical specialists who are highly qualified to diagnosis. Every chiropractic patient should be mindful of his own symptoms and should secure medical opinion if he has any concern as to the nature of his illness or injury. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you should take the initiative if in doubt.

CHIROPRACTIC ADJUSTMENTS:

The patient, in coming to the chiropractic gives the chiropractor permission and authority to adjust the patient in accordance with the chiropractic analysis. The chiropractic adjustment is usually beneficial and seldom causes any problem. In rare cases underlying physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor of course, will not give a chiropractic adjustment if he is aware that such conditions exist. Again, it is the responsibility of the patient to make it known, to learn through medical procedures whether he is suffering from latent pathological defects illness or deformity which otherwise would not come to the attention of the chiropractor. The patient should not look to the Doctor of Chiropractic for indepth diagnosis procedures. The Doctor of Chiropractic provides a specialized health service, does not and should not become involved in the patient's medical regimen. A patient should never ask or accept advice from a chiropractor concerning the taking of prescriptive medicines. The Doctor of Chiropractic is not licensed in medical practices.

RESULT:

The purpose of chiropractic services is to promote natural health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes the response is phenomenal, In some cases, there is more gradual, but quite satisfactory response. Occasionally, the results are mediocre or dismal. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond chiropractic care, may come under control or be better treated through medical science. The fact is, the sciences of chiropractic and medicine may never be so exact as to provide definite answers to many problems. Both have made great strides in alleviating pain and controlling disease.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

ACKNOWLEDGEMENT:

I HAVE READ THE FOREGOING AND UNDERSTAND IT. Signed this day of _____, _____.

SIGNATURE

COPYING OF X-RAYS

If you have supplied your own x-rays at the time of examination or will receive x-rays at our clinic, please note the following policy and sign below:

“ I understand that all records/ x-rays supplied by me and/or taken by the Zivkovic Chiropractic Center will become part of my permanent records and remain in the custody of this clinic. I am entitled to obtain copies at any time of my records as long as I sign an authorization for their release and agree to pay the cost of copying those records. I understand that I must give at least 10 (ten) days notice to the Zivkovic Chiropractic Center to allow ample time for copying of my records.”

Patient Name : _____

Signature : _____

Date : _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES/ WRITTEN ACKNOWLEDGMENT FORM

**I acknowledge that I have reviewed a copy of Zivkovic Chiropractic Center’s Privacy Practices.
(If you would like a copy to take home please request it at the front desk)**

I allow the following individual(s) to be given information regarding care

Patient/ Legal Guardian Print: _____

Patient or Legal Guardian Signature: _____

Date: _____