JOURNEY
CHIROPRACTIC CLINIC

Journey Chiropractic
10445 SW Canyon Rd, Suite 101
Beaverton, OR 97005
971-238-9464
journeychiropracticpdx.com

New Patient Paperwork

(If you are seeing us for a motor vehicle collision or a workplace accident please let us know so we can get you different paperwork.)

About You

Name:_____Gender: ○ Male ○ Female
Address:_____
City:_____State:_____Zip:_____
Home Number:_____Work Number:_____Other Number:_____
Email Address:_____
Date of Birth(MM/DD/YYYY)_____ Age:_____
Marital Status: ○ Single ○ Married ○ Other If married please provide spouse's name:_____
If Patient Is a Minor, Name of Parent(s):_____
Primary Care Physician:_____

Emergency Contact

Name:_____Relationship:_____
Contact Number:_____

Employment Information

Status: ○ Full Time ○ Part time ○ Unemployed ○ Student ○ Retired ○ Homemaker
Occupation:_____
Employer:_____
Job duties:_____

How Did You Hear About Us?

(please check all that apply)

○ Google ○ Yelp ○ Facebook ○ Chamber of Commerce ○ Walk/drive by ○ Instagram
○ Referred by:_____ ○ Insurance Company:_____
○ Local Event:_____ ○ Other:_____

For Office Use Only

Patient Info: ☐ Demographics ☐ Primary prov. ☐ Billing prov. (use appt. prov) ☐ Emp. info ☐ Fee sched
Dx: ☐ Date of Current Illness (for MVA or WC it is the date of accident; for all others pick today's date
Insurance Tab 1: ☐ Policy info ☐ Pt. resp. ☐ If e-billing: batch claims, e-claims, EDI **Tab 2:** ☐ Copy pt. Info ☐ Group #
Records: ☐ Scan ID/ins card ☐ Scan intake paperwork ☐ Scan insurance benefits **Completed by:**_____

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Patient Name:_____ DOB:_____ Provider:_____ Date:_____

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What Brought You In Today

Date problem began?:_____ Present issue:_____

Briefly describe injury details:_____

_____

Does anything increase or decrease your pain?_____

On a scale of 1-10(10 being the worst) how bad is your pain?_____

Is you pain: Constant Intermittent

Is your pain worse during: Morning Afternoon Evening No difference

How did your pain begin?

- ❑ Immediately after a specific event
- ❑ Multiple events
- ❑ Gradually developed
- ❑ No apparent reason

Have you had a similar problem before? Yes No

Have you received prior care for this issue? Yes No

If yes, what:_____

Current Symptoms Update

(Please check all that apply)

❑ Fever	❑ Fatigue	❑ Bleeding	❑ Diarrhea
❑ Night Sweats	❑ Sore Throat	❑ Poor Circulation	❑ Rash
❑ Chest Pain	❑ Cough	❑ Dizziness	❑ Numbness
❑ Nausea	❑ Vomiting	❑ Hot Flashes	❑ Bruising
❑ Weight Loss	❑ Changes in Vision	❑ Difficulty Breathing	❑ Anxiety
❑ Muscle Weakness	❑ Constipation	❑ Difficulty Sleeping	❑ Tension
❑ Urinary Tract Infection	❑ Respiratory Infection	❑ Skin infection	❑ Loss of Bowel or Bladder Control
❑ Painful/Swollen Joints	❑ Difficulty Swallowing	❑ Immune System Dysfunction	❑ Other _____

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Personal Medical History

(Please check all that apply)

❑ Diabetes	❑ Ulcers	❑ Cancer	❑ AIDs/HIV
❑ Joint Replacement	❑ Stroke	❑ Arthritis	❑ Seizures
❑ Glaucoma	❑ Hepatitis	❑ Anemia	❑ Alcoholism
❑ Lung Disease	❑ Heart Disease	❑ Diverticulitis	❑ Pacemaker
❑ Kidney Disease	❑ Thyroid Disease	❑ Tuberculosis	❑ Hypertension
❑ Blood Thinners	❑ Depression	❑ Anxiety	❑ Other_____

Surgeries/Hospitalizations/ Major Injuries/Fractures/Dislocations:_____

_____

Current Medications:_____

Lifestyle Habits

Tobacco: Yes No If yes, frequency?:_____ How long have you used tobacco?_____
Caffeinated Beverages: Yes No If yes, #/day?_____
Alcoholic Beverages: Yes No If yes, #/day?_____
Other Substances: Marijuana Cocaine Non-prescription Opiates Other:_____
Do you currently exercise regularly? Yes No
Other information we should know about:_____

_____

Family Medical History

(Please check all that apply)

❑ Diabetes	❑ Hypertension	❑ Cancer	❑ Scoliosis
❑ Heart Disease	❑ Stroke	❑ Osteoarthritis	❑ Muscle Disease
❑ Rheumatoid Arthritis	❑ Other_____		

Other information we should know about:_____

_____

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HIPAA

Acknowledgement of receipt of Notice of Privacy Practice Regarding the Use & Disclosure of Protected Health Information (Consent Form)

For the purposes of this Consent Form, "Office" shall refer to: **Journey Chiropractic**.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices". I understand that I may review this privacy notice at any time prior to signing this form.

Text

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

I have also given authorization to

_____

(Person's name and relationship to patient)

to access information on my account.

Patient Name (please print):

_____

Signature: _____ Date: ____/____/____

If patient is a minor

_____ Date: ____/____/____

Signature of Patient Representative
(Required if patient is a minor or adult unable to sign this form)

Relationship to Patient: _____

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Financial Agreement

Please remember that insurance is considered a method to reimburse the patient for fees put to the doctor and it is NOT A SUBSTITUTION FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balances not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.
If this account is assigned to an attorney/outside agency for collections and/or suit, Journey Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

Patient Signature Date

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Journey Chiropractic all medical benefits and/or insurance reimbursement. If any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan, any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to any medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature (Insured or Guardian) _____ Date _____

Print Name _____

Patient Name: _____ DOB:_____Today's Date:_____