Date: _____

Dr. Zandall J. Carpenter

New Patient Information

Name: _____ Home phone #_____ Work phone #_____

Cell phone #_____ Okay to leave a message? Yes/No____ E-Mail_____

Address_____ City_____ State_____ Zip_____

Birth date ____/____/_____ Height_____ Weight_____ Age_____ Marital Status_____

Employer_____ Occupation_____ Social Security #_____

Referred by_____ Spouse_____ Phone #_____ Employer_____

Insurance Information: please check one.

Auto accident_____ Work comp_____ Private insurance_____ Medicare_____ Personal payment_____ Other_____

Dr. Carpenter is a preferred provider for Aetna, Cigna, Lovelace, Blue Cross Blue Shield, Presbyterian and United Healthcare. We are a **non-participating** provider for Medicare. Medicare patients will need to pay for your visits and our office will submit claims to Medicare. We **do not** file with secondary insurance. If a reimbursement is made it will come directly from Medicare to the patient.

Please provide the front desk with a copy of your insurance card.

Insurance company_____ Policy/Claim #_____

Address_____ City_____ State_____ Zip_____

Phone #_____ Adjuster_____

Accident/Injury Information:

Date of accident____/____/_____ Time_____ AM/PM? Description: _____

_____

Has the employer been notified? _____ Have you been placed on disability? _____ Dates: _____

Have you been treated for this condition previously? _____ Doctor? _____ Results_____

Health History:

List all medications, vitamins, and supplements you are presently taking: _____

_____

Do you have TB? _____ Cancer? _____ Diabetes? _____ Stroke? _____ Heart attack? _____

Allergies? _____

List any surgeries and procedures, past and present: _____

_____

List previous accidents, injuries, and major illnesses_____

_____

List any sports history, past and present_____

_____

Family physician_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Family Medical History: _____

_____

_____

Emergency Contact: _____ Relationship: _____

Phone number#_____ Alternate phone #_____

Patient Symptoms

Please circle present symptoms.

Muscle, Ligament, and Joint:
Neck: Weakness / Pain / Stiffness / Swelling / Spasms / Disc limited movement / Pain with motion / Surgery / Throat muscles swollen or sore
Worse: After sleeping / Daytime / End of the day
Mid-Back: Weakness / Pain / Spasms / Soreness
Worse: After sleeping / Daytime / End of the day
Low Back: Weakness / Pain / Stiffness / Swelling / Limited movement / Pain with motion / Pain when sitting / Standing / Sleeping
Worse: After sleeping / Daytime / End of the day
Sacroiliac: Tailbone / Sex impotency / Pain in the groin
Worse: After sleeping / Daytime / End of the day

Extremities & Radiating Pain:
Head and Headaches: Side / Front / Top / Heavy Head / Affects vision / Nausea / Throbbing / Incapacitating / Handicaps normal function / Migraine
Worse: After sleeping / Daytime / End of the day
Shoulder: Local pain / Radiates down arm / Pain on movement / Limited movement / Pain from neck
Worse: After sleeping / Daytime / End of the day
Arm: Local pain / Radiating pain / On movement / Down arm / Numbness / Tingling / Elbow / Wrist / Fingers / Swelling / Heaviness / Cold hands / Grip strength loss / Unable to raise arm
Hips, Knees, and Legs: Local pain / Radiating pain / On movement / Down leg / Knee, front or back / Numbness / Tingling / Knee swelling / Ankle swelling / Charlie horses / Cramps / Spasms / Varicose veins Heaviness / Pain on walking / Sitting / Prolonged standing
Feet: Swelling / Discomfort / Pain / Pain on walking / Pain with back problems / Corns / Bunions / Fallen arches / High arches / Toe in / Toe out / Cold Burning

Muscles and Ligaments: Sprain / Pulled / Torn / Atrophy

Spine and Disc
Spine: Surgery / Arthritis / Curvature / Whiplash
Disc: Surgery / Protrusion / Compressed / Degeneration / Deteriorating / Ruptured / Herniated

Nerves: Burning / Numbness / Tingling / Pins and needles / Tremor / Nervousness / Nervous tension / Nervous fatigue / Dizziness / Poor equilibrium / Loss of balance

Low Energy and Fatigue: Occasional / Constant / Exhaustion build up / Tired upon waking / Exhaustion after work / Must rest during the day / Emotional fatigue
Sleeping: Good / Fair / Poor due to pain / Insomnia / Excessive

Eyes Ears, Nose, Throat, and Mouth:
Eyes: Pain / Strain / Red / Blurring / Sensitivity to light / Double vision / Spots / Injury / Pressure / Far sighted / Near sighted / Failing / Glasses
Hearing: Good / Poor / Hearing-Aid / Failing
Nose: Post-nasal drip / Bleeding / Sneezing / Loss of smell
Throat: Sore / Dry / Hoarse / Phlegm / Enlarged glands / Difficulty swallowing
Mouth: Bad taste / Breath / Gums / Sores / Loss of taste
Teeth: Good / Poor / Abscess / Grinding / Dentures / Fit well / Fit poor

Heart and Circulation
Heart: Slow / Rapid / Palpitation / Past heart attack / Coronary / Chest pain / Pain down arm / Difficulty breathing / Hardening of the arteries
Blood: Problems / Disease / Anemia
Blood pressure: High / Low / Irregular / Past stroke / Paralysis / Left / Right
Circulation: Good / Poor / Swelling
Cold: Hands / Feet / Body / Varicose veins
Sweats: Excessive / Hot / Cold / Night

Lungs & Breathing: Lungs: Difficulty breathing/Congestion/Asthma/Emphysema/Wheezing/Bronchitis
Cough: Blood/Phlegm/Dry/Sneezing

Stomach, Liver, Gall Bladder, & Intestinal:
Stomach: Nausea/Pain/Ulcer/Vomiting blood/Bile/Indigestion/Heartburn/Gas
Appetite: Good/Poor/Excessive
Liver: Upset/Jaundice/Hepatitis
Gall Bladder: Attack/Infection/Stones
Intestines: Bloat/Mucous/Constipated/Diarrhea/Hemorrhoids/Fissures/Colitis

Kidney, Bladder & Urination:
Urine: Frequent/Difficult/Burns/Blood/Pus/Irritates/Cloudy/No Control/ Infection/Kidney stones/Prostate Bedwetting

Skin: Sensitive/Bruises easily/Dry/Itching/Rash/Hives/Shingles/Boils/Acne/Eruptions/Slow healing

General:
Cold symptoms: Chills/Fever/Flu Symptoms/Virus/Chronic cold/Cough
Swollen Lymph Nodes: Neck/ Underarm/Throat
Sinus: Congestion/Headach/Sneezing
Weight: Over/Under/Loss/Gain
Reaction to Drugs: Mild/Severe/On occasion

Personal Habits:
Hours Regular Sleep: _____ per night
Smoking: _____ packs per day
Coffee/Tea: ____ cups per day
Hours worked: ____ day/ ____week

For Women only:
Menstral: Cramps/Backache/Excessive flow/Difficult/Irregular/Tension/PMS
Menopause: Symptoms/Hot Flashes/Estrogen
Vaginal: Discharge/Irritation/Odor
Currently Pregnant/Miscarriages: ___ Pregnancies: ___ Fertility Problems/ Self/Husband

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Absolutely no patients accepted for diagnosis or treatment of Cancer. Suspected cases of Cancer are immediately referred.

Date: _____ Patient Name: _____

Dr. Zandall Carpenter

Financial Policy

We are committed to providing you with the best possible care and are happy to discuss our professional fees with you at any time. Our goal is to put you back in control of your health and provide you with high quality health care at a reasonable fee. Your clear understanding of our financial policy is important to our professional relationship.

Private Payments:

Payments are expected at the time of service. We accept cash, checks, and all major credit cards. If there is a problem with payment, let us know immediately. We do not want financial problems to interfere with your care.

Insurance:

Payments are expected at the time of service. Patients are responsible for co-pays, co-ins, deductibles, and balances after maximums are met. We gladly fill out and submit all insurance forms and claims for you to the insurance companies that we are preferred providers with. We are not able to file claims with companies we are not in network with. Remember your insurance policy is a contract between you, your employer and your insurance company. As health care providers our relationship is with you, the patient, not your insurance company. Please refer to your insurance company's agreement for chiropractic care benefits.

Personal Injury/Auto:

We will accept Med-Pay (medical coverage on your auto-insurance policy) and Third Party cases. You will need to provide our office with a claim number, phone number, and billing address or fax number. Med-Pay will cover your doctors' bills regardless of who was at fault. We will bill your auto-insurance company for prompt and direct payment for your care up to your policy limits. If it is a Third Party case, we ask for an Attorney's Letter of Protection. Payment is expected in full upon case settlement. The patient is ultimately responsible for any and all services rendered.

Missed Appointments:

There is a $50.00 fee for missing your appointment. We also implement this fee when there is less than 24 hours notice of cancellation. Emergencies and illness will be taken into consideration when applying this fee.

Returned Check:

If for any reason this unfortunate situation arises, the patient will be charged a $25.00 fee per occurrence.

I, the undersigned, have read and accept the above stipulations. I am ultimately responsible financially for services rendered. I also understand that any balance left on my account may be subject to interest at 1.5% per month or 18% annual retroactive. I will be financially responsible if a collection agency is utilized.

Responsible Party Signature:_____ Date:_____

Authorization Form

Dr. Zandall Carpenter

Authorization is hereby granted to Dr. Zandall Carpenter to release any information acquired in the course of my examination and treatments to any insurance company, attorney, or adjuster. I, _____ authorize and assign direct payment to Dr. Zandall Carpenter of any sum I now or hereafter owe this office by my attorney out of the proceeds of any settlement of my case and/or by an insurance company obligated to reimburse me for the charges of these services.

I clearly understand and agree that health and accidental insurance policies are an arrangement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment, and I agree to pay any and all outstanding billing on a timely basis. I also understand that any amount authorized to be paid directly to this office will be applied to any outstanding balance that I owe.

I understand that in personal injury cases payment may be deferred until settlement, with the total due in full at settlement, providing that no other insurance is involved and if an attorney approved by this office is representing me.

I further understand that if I suspend or terminate my treatment in this office or if I discharge my attorney or he/she discontinues my representation, any fees for professional services rendered to me will be **immediately due and payable**. I also agree to pay any and all reasonable legal fees and court cost incurred on the collection of this account.

Limited Power of Attorney: I hereby grant to the physician/facility named above power to endorse upon any checks, drafts, or other negotiable instrument representing payment from any insurance company or attorney's office for payment of treatment and health care rendered by the physician/facility. I agree that any insurance payments representing any amount in excess of charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

Patient Signature: _____ **Minors Name:** _____

Witness: _____ **Parent/Guardian:** _____

Date: _____

Dr. Zandall Carpenter

Notice of Informed Consent

Every type of health care is associated with some risk of potential problem. This includes chiropractic care. We want you to be informed about the potential problems associated with chiropractic care before consenting to treatment.

Subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of their normal alignment. This can occur through recent or remote trauma as well as unusual positions in which we find ourselves throughout the day or night. A Subluxation has also been described as an incomplete dislocation of a joint and as such, it is not treated with drugs or surgery. Chiropractors treat vertebral Subluxation with a spinal manipulation, (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently adjustments create a popping or clicking sensation in the area being treated.

In our office we use highly trained staff to assist the doctor with portions of your consultation, examination, and therapies.

Stroke: There is a remote chance (1:6,000,000) of a rare type of stroke associated with manipulation of the cervical spine. The particular adjustment associated with this risk is NEVER PREFORMED IN THIS OFFICE.

Disc Herniation: Disc herniations that create pressure on the spinal nerves or the spinal cord in the neck or low back are treated successfully by chiropractors with adjustments and spinal decompression. Occasionally these treatments can irritate this problem, but the treatments administered in this office will not worsen the dis herniation. To help prevent this, patients are put through a specific range of motion tests and procedures during the examination to see if any of these positions might aggravate disc symptoms. Because of such careful attention to detail, these complications occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely will a chiropractic adjustment, traction, massage, and other treatments strain some muscle or ligament fibers. The result is a temporary increase in pain requiring specific treatment for resolution with no long term affects to the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: Rarely, a chiropractic adjustment may break a rib, this is referred to as a fracture. This occurs only to those patients with weakened bones from such things as osteoporosis, prolonged steroid use, or other bone-weakening diseases. These conditions can be ruled out in the history or x-rays. We adjust all patients carefully and especially those with bone-weakening conditions. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms genetae heat. We use different forms of heat and ice in the office and occasionally recommend them for use at home. Everyone's skin has a different sensitivity to these modalities, and rarely can heat or ice irritate the skin. The result is a temporary increase of skin pain and possible minor blistering. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is not uncommon for spinal adjustments, traction, massage, exercise and other therapies to result in a temporary increase in soreness to the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell the doctor or a staff member about it.

Other Problems: There may be other problems or complications that arise from chiropractic treatment other than those mentioned above. There other complications occur so rarely that it is impossible to anticipate or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore as with any health care delivery system we cannot promise a cure for all symptoms, diseases, or conditions as a result of treatment at this facility. We will always give you the best care we can deliver and if the results are not acceptable we will gladly discuss other types of treatment options or refer you to another health care provider for alternative types of treatment.

If you have any questions about the above information, please ask your doctor to explain them in more detail.

Authorize to Treat: I, the undersigned, hereby authorize Dr. Zandall Carpenter to administer such chiropractic, physical therapy, and/or therapeutic treatment or medical procedures as he considers therapeutically necessary on the basis of findings during the set course of treatment.

Patient Signature:_____ Date:_____

Consent to Treatment of a Minor: I, the undersigned, hereby authorize Dr. Zandall Carpenter to administer such chiropractic, physical therapy, and/or therapeutic treatment or medical procedures as he considers therapeutically necessary on the basis of findings during the set course of treatment to

Minor's Name: _____ Parent/Legal Guardian: _____