

Patient Information

Date _____

SS#/Patient # _____

Patient Name _____
Last Name First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____ **FT or PT**

Patient Employer/School _____

Employer/School Address _____

City _____

State _____ Zip _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Print

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. **CYNTHIA S. OCHI** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Phone Numbers

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

Accident Information

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

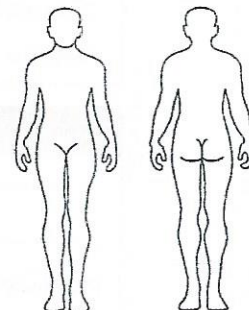
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

EXERCISE	WORK ACTIVITY	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking _____ Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol _____ Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks _____ Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

OFFICE POLICIES FOR DR. CYNTHIA S. OCHI

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 office and patient.

Please speak to: **KRISTIN** Office/Billing Manager at the front desk.

PAYMENT: We accept cash, check, credit/debit (FSA/HSA cards).

-Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made.

-If account is not paid within an appropriate time and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in the collection of your account.

-There will be a charge of \$35.00 for a returned check.

BROKEN APPOINTMENTS: There will be a **\$20.00** charge for appointments broken without a 24 hour advance notice. (No shows, cancellations, and re-schedules, these fees will be collected upon arrival of your next visit)

-To help keep track of appointments, our software program automatically sends reminders via e-mail and mobile messaging. **Add your e-mail & cell # on our Welcome Form.**

SPECIALIST: Please keep in mind that Dr. Ochi is considered a specialist with insurance therefore co-payments may be higher than that of a PCP.

MEDICARE PATIENTS: Must sign an ABN.

-Medicare will only cover "**acute treatment**", maintenance is **NOT** covered.

-You are responsible for you 20% co-insurance per visit unless supplemental coverage covers your balance. If you have a secondary insurance that has a copay, you will be responsible.

INSURANCE ASSIGNMENT OF BENEFITS: Please Initial _____

-I hereby authorize assignment of my insurance rights & benefit directly to the provider for services rendered. Please note that insurance benefits may be subject to medical necessity, # of visits, copays, deductibles, and co-insurance. I authorize the provider to release any information required to process claims. **I fully understand I am solely responsible for any unpaid balance not paid by my insurance company. There is no expiration on these policies. I have read the office policies; I understand & agree to them. I have also received a copy of the privacy policies.**

SIGNATURE _____ DATE _____