WELCOME

Boykin Chiropractic Care, P.C.
P.O. Box 730
Elizabeth, CO 80107
(303) 646-0893

PATIENT INFORMATION

Date _____ For Office Use Only: ☐ NPL ☐ RFL _____

Email: _____

Name _____
Last First Middle Initial

Mailing Address _____
P.O. Box City State Zip

Physical Address _____
Street Address City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____ Patient SS# _____

Occupation _____ Full time ☐ Part time ☐

Employer _____ Retired ☐ Student ☐

Employer Address _____Employer Phone _____

Marital Status _____ Spouse's Name _____

Spouse's Employer _____ Spouse's Phone _____

Whom may we thank for referring you?_____

PHONE NUMBERS

Home_____ Cell Phone_____Work _____

Best time and place to reach you_____

If you are unavailable which numbers may we leave a message for you on: ☐Home ☐Cell ☐Work ☐All

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Home Phone _____ Work/Cell Phone_____

INSURANCE

Subscriber Name/SSN_____

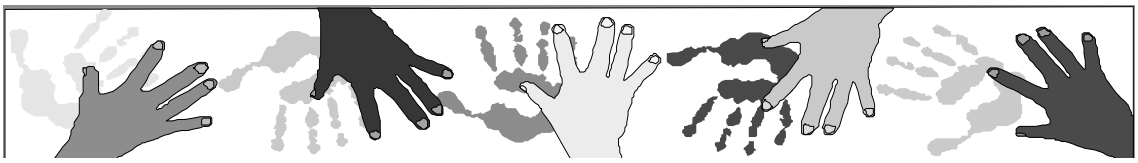
Relationship to Patient_____ Insurance Co._____

Group No._____ Policy No._____Phone No._____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ _____ and assign directly to Dr. Boykin 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Date Relationship



Boykin Chiropractic Care, P.C.
P.O. Box 730
Elizabeth, CO 80107
(303) 646-0893

Patient Name_____ Date_____

PATIENT CONDITION

Reason for Visit_____

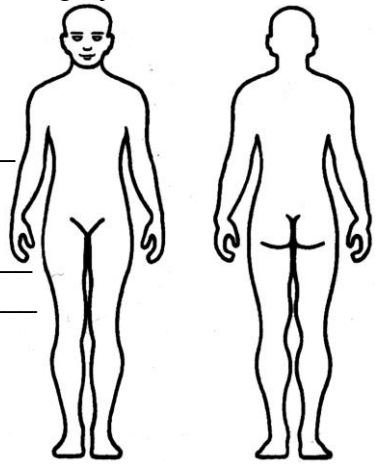
_____

When did your symptoms appear?_____

What treatment have you already received for your condition? ☐ Medications ☐ Surgery
☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

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

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date of accident _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp. ☐ Other

Attorney Name (if applicable) _____ Phone Number _____

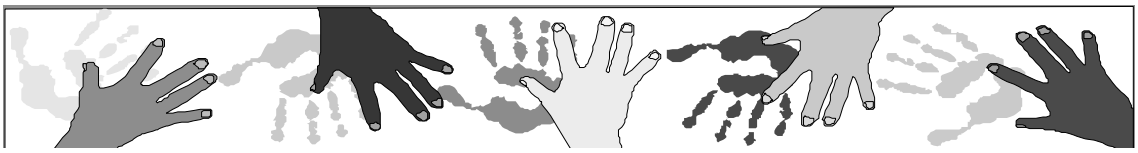
HEALTH ATTITUDES

☐ **Treatment Only.** I only consult a doctor when I have an ache or a pain and discontinue care as soon as it has cleared up.

☐ **Prevention.** In addition to symptomatic treatment, I consult specialist occasionally to prevent problems from recurring.

☐ **Maintaining Health.** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.

☐ **Family Health.** I take an active part in assisting, informing, and maintaining health with my family. I'm concerned with the long-term affects of good health.



Boykin Chiropractic Care, P.C.
P.O. Box 730
Elizabeth, CO 80107
(303) 646-0893

Patient Name_____ Date_____

FINANCIAL POLICY AND ARRANGEMENTS

I understand that my chiropractic care in this office may vary in cost, depending on what services I receive. The policy I choose is:

☐ **The Paperwork Reduction Plan –** A time-of-service discount is given when you pay at the time of the visit. No balances are carried. You keep the care schedule you have set with the doctor and you are only entitled to a paper receipt. There is no other paperwork given with this plan.

☐ **The Necessary Paperwork Plan –** This plan applies to patients who wish to utilize insurance benefits. Our standard fee schedule is used to bill the insurance carrier. The patient is responsible for paying all deductibles and co-payments. Boykin Chiropractic Care, P.C. will provide a courtesy call to the insurance carrier to verify coverage; write all required reports and diagnosis; prepare/send insurance bills and make status calls. This plan allows you to carry a balance, after paying your deductible and/or co-pay, for up to 60 days while your insurance company processes your claim.

I fully understand and agree that I am directly and fully responsible to pay in full for all professional services and/or products provided to me and/or my dependents provided by this office whether or not they are covered by insurance. I further understand and agree that such payment is not contingent upon any settlement, claim, judgment or verdict by which I may eventually recover said fee. I also agree to pay all reasonable costs of collection, attorney fees and interest at the ANNUAL PERCENTAGE RATE of 21% (1.75% PER MONTH) on any PAST DUE BALANCE (over 60 days old). Boykin Chiropractic Care, P.C. requires full payment for initial services rendered. If your insurance carrier provides chiropractic coverage we will notify you of the specific coverage and deductibles met. We will either reimburse the difference or the patient may opt to apply the balance against a co-pay once the insurance company pays Boykin Chiropractic Care, P.C. I hereby authorize Boykin Chiropractic Care, P.C. to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

Date_____ **Patient/Guardian Signature** _____

INFORMED CONSENT/TERMS OF ACCEPTANCE

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

The purpose of chiropractic is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine, which interfere with the function of these nerve pathways, are called subluxations.

By means of chiropractic adjustments, subluxations are corrected, thus restoring normal nerve function. The goal of chiropractic is to correct vertebral subluxations for the purpose of restoring the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times.

This allows the innate healing ability of the body to work at maximum efficiency.

With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it. Our only goal is to allow the body to do its job. Our only means is the correction of vertebral subluxation. We promise no cure from and offer no treatment of disease.

Date_____ **Patient/Guardian Signature**_____

HEALTH HISTORY

Boykin Chiropractic Care, PC ▪ PO Box 730 ▪ Elizabeth, CO 80107
(303) 646-0893

Patient Name: **Date:**

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	_____		

Have you ever suffered from the following:

□ AIDS/HIV	□ Chicken Pox	□ Migraine Headaches	□ Scarlet Fever
□ Alcoholism	□ Diabetes	□ Miscarriage	□ Stroke
□ Allergy Shots	□ Emphysema	□ Mononucleosis	□ Suicide Attempt
□ Anemia	□ Epilepsy	□ Multiple Sclerosis	□ Thyroid Problems
□ Anorexia	□ Fractures	□ Mumps	□ Tonsillitis
□ Appendicitis	□ Glaucoma	□ Osteoporosis	□ Tuberculosis
□ Arthritis	□ Goiter	□ Pacemaker	□ Tumors, Growths
□ Asthma	□ Gonorrhea	□ Parkinson's Disease	□ Typhoid Fever
□ Bleeding	□ Heart Disease	□ Pinched Nerve	□ Ulcers
□ Disorders	□ Hernia	□ Pneumonia	□ Vaginal Infections
□ Breast Lump	□ Herniated Disk	□ Polio	□ Venereal Disease
□ Bronchitis	□ Herpes	□ Prostate Problem	□ Whooping Cough
□ Bulimia	□ High Cholesterol	□ Prosthesis	Other _____
□ Cancer	□ Kidney Disease	□ Psychiatric Care	_____
□ Cataracts	□ Liver Disease	□ Rheumatoid Arthritis	_____
□ Chemical Dependency	□ Measles	□ Rheumatic Fever	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
□ None	□ Sitting	□ Smoking	Packs/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/Week _____
□ Daily	□ Light Labor	□ Coffee/Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ 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(RX/OTC)	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone **(**____**)**_____	_____	_____

Patient Signature: _____