Patient Information

Legal First Name: _____ **MI:** _____ **Last Name:** _____

Street: _____ **Apt:** ___

City: _____ **State:** _____ **Zip:** _____

Social Security #:_____--_____--_____ **Marital Status: S M W D**

Spouse:_____

Is the patient a minor? ___ **Yes** ___ **No** **Guardian Signature (if yes):**_____

Gender: M F Other:_____ **Height:** _____ **Weight:** _____

DOB: _____

Home Phone: _____ **Work Phone:**_____

Cell Phone: _____

Cell Carrier_____

Email:_____

Please circle your contact preference: Cell Home Work Email Postal Mail

Emergency Contact:_____
Phone Number:_____

Occupation: _____

What is your current work status?
__ Full time, no restriction __ Part time, with restrictions__ Unemployed Other: _____
__ Full time with restrictions __ Off work due to restrictions __Retired
__ Part time, no restrictions __ Full time homemaker __ Full time student

Whom may we thank for referring you to our office?

_____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name:
_____

Policy Holder's Date of Birth: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's:
First Name: _____ M.I. ____ Last Name: _____

Policy Holder's Date of Birth: _____

Auto Accident Info

Date of Accident: _____

Insurance Carrier: _____

Insured's Name: _____

Claim #: _____

Adjuster Phone: _____ Fax: _____

Claim Address: _____

PIP (Personal Insurance Policy) has been: ___ Filed ___Exhausted ___Waived

Attorney Name: _____ Phone:_____

Address:

_____

_____

Worker's Compensation Info

Date of Accident: _____ Employer: _____

Adjuster Name: _____

Adjuster Phone: _____ Fax: _____

Claim Address: _____

Please describe your complaint:

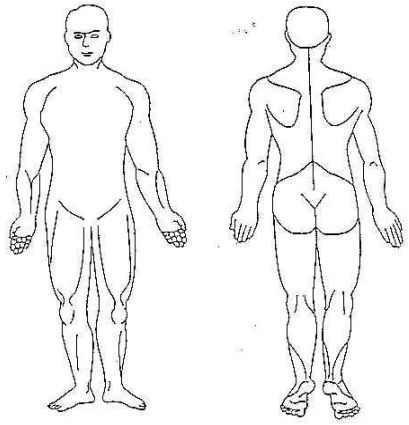
_____

_____

_____

Description		**Frequency**	
__	Sharp Pain	__	Constant (76-100%)
__	Dull Pain	__	Frequent (51-75%)
__	Ache	__	Occasional (26-50%)
__	Weak	__	Intermittent (25% or less)
__	Throbbing		
__	Numb		
__	Shooting		
__	Gripping		
__	Burning		
__	Tingling		

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



c. Indicate intensity of your pain at its highest level. No Pain 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 Unbearable

d. Your symptoms are: __ decreasing __ not changing __increasing

e. Symptoms are worse in the: __ morning __ afternoon __ night __ increase during the day __ same all day

Describe when and how your problem began:

_____

_____

_____

Have you been treated for this episode? __ Yes __ No

If yes, by whom? __Chiropractor __ MD __ Osteopath __Physical Therapist __ Occupational Therapist
Other: _____

Are you currently being seen? __ Yes __ No
When were you seen and what treatment was given?

_____

_____

In the past, have you been treated for the same or similar problem? __ Yes __ No

If yes, by whom? __ Chiropractor __ MD __ Osteopath __ Physical Therapist __ Occupational Therapist
Other: _____
When were you seen and what treatment was given?

_____

_____

What makes your problem better? __ Nothing __ Lying Down __Walking __ Standing __ Sitting
__Movement/Exercise __ Inactivity

What makes your problem worse? __ Nothing __ Lying Down __ Walking __ Standing __ Sitting __Movement/Exercise __ Inactivity

General Physical Activity: __ No regular exercise __ Light exercise __ Moderate exercise __ Strenuous exercise

Are your complaints affecting your ability to be active?

__ No effect __ Some physical restrictions (able to perform light duty work and household tasks)
__ Need limited assistance with common everyday tasks. __ Need assistance often
__ Have a significant inability to function without assistance. __ Am totally disabled (impaired).
__ Cannot care for self.

MAJOR ILLNESSES: If you have ever had a listed condition in the past, please check it in the ***Past*** column. If you are presently troubled by a particular condition, check it in the ***Present*** column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Past	Present		Past	Present	
__	__	Abdominal Pain	__	__	High Blood Pressure
__	__	Abnormal Weight __Gain __Loss	__	__	HIV/AIDS
__	__	Aortic Aneurysm	__	__	Impaired Muscular Coordination
__	__	Arthritis	__	__	Kidney Stones
__	__	Asthma	__	__	Liver/Gallbladder Problems
__	__	Blood Disorder	__	__	MS (Multiple Sclerosis)
__	__	Cancer	__	__	Painful Urination
__	__	Chest Pains	__	__	Pregnancy
__	__	Convulsions	__	__	Prostate Problems
__	__	COVID-19 (Date:_____)	__	__	Rapid Heartbeat
__	__	Depression	__	__	Rheumatoid Arthritis
__	__	Diabetes	__	__	Stroke
__	__	Dizziness	__	__	Swelling/Stiffness of Joints
__	__	Fainting	__	__	Systemic Lupus
__	__	Frequent Urination	__	__	Tinnitus (Ear Noises)
__	__	General Fatigue	__	__	Tumors
__	__	Headaches/Migraines	__	__	Vertigo
__	__	Heart Attack	__	__	Visual Disturbances
__	__	Heartburn/ Indigestion			

Does your family have a history of any of the following?

__ Cancer
__ Rheumatoid Arthritis
__ Diabetes
__ Heart Problems
__ Lung Problems
__ High Blood Pressure
__ Epilepsy
__ Chronic Back Problems
__ Chronic Headaches
__ Lupus
__ Other Conditions: _____

Do you have a permanent disability rating? ____ Yes ____ No

Location: _____

Date rating received: _____

Rating Percentage: _____

Medications:

What medications are you currently taking?

_____

_____

_____

Surgeries:

Please list any past surgeries, including the approx. dates:

_____

_____

_____

Do you have allergies? □Food □Environmental □Medication

List Type of Allergy and Reaction

_____

_____

_____

Assignment & Release

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mediquest, LLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient/Parent/Guardian Signature: _____ Date: _____

Consent of Professional Services and Release of Information

I hereby authorize and release Dr. Marlene N. Mahipat and whomever she may designate as her assistants, to administer treatment, physical examination, chiropractic care or any clinical services she deems necessary in my case; I furthermore authorize her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds or the patient's employer.

Patient/Parent/Guardian Signature: _____ Date: _____

Missed Appointment and Cancellation Policy

I understand and agree that if I am unable to keep my scheduled appointment, I must give a **24 hours** advance notice, and I will make up my missed appointment by rescheduling, otherwise I will be charged a **$30** missed appointment fee and/ or a **$30** cancellation fee.

Patient/Parent/Guardian Signature: _____ Date: _____

Notice of Privacy Practices Written Acknowledgement

I have been informed of the Notice of Privacy Practices of this office.

Patient/Parent/Guardian Signature: _____ Date: _____

Mediquest. LLC. Marlene N. Mahipat D.C.

5310 Old Court Rd. Suite 301 Randallstown, MD 21133 (410) 655-8900 fax (410) 655-0498

Informed Consent

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It however, has one of ***safest*** records of the wide range of treatments that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasms or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

Disc injury from manipulation causing spinal cord pressure	**Neurological complication from Neck surgery**	**Back surgery**
1 per 100 million	**1 per 64**	**1 per 333**

Artery injury from Manipulation causing stroke	**Death rate from neck surgery**
1 per 1 million	**1 per 145**

Perhaps the most common alternative to spinal manipulations is the use of anti-inflammatory drugs. These drugs cause fairly and potentially serious complications

Complications associated with anti-inflammatory drug use:

Serious stomach or intestinal bleeding	**1-4 per 1000 users**
Hospitalizations from complications	**20,000 per year**
Deaths from complications	**16,500 per year**

(New England Journal of Medicine, 6/99)

I have read the above and understood the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Mediquest, LLC.

Name: _____ Signature: _____ Date: _____

"Gentle, Effective, Quality Chiropractic Care"

*** Member, Maryland Chiropractic Association***

Mediquest. LLC. Marlene N. Mahipat D.C.

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ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to Mediquest such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other Insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be adequately necessary to protect this office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name of in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute and consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any Insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien AND Authorization. I agree that the above mentioned office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

Date:_____ Signed:_____