

Willow Bend Sports & Spine Center

Improving Lives & Performance

New Patient Information / Change of Address

Date _____

New Patient _____ Change of Address _____

Patient Name _____

Date of Birth _____ Age _____

Gender (circle one) MALE FEMALE

Marital Status (circle one) SINGLE MARRIED DIVORCED WIDOWED

E-Mail _____

Address _____

City, State, Zip _____

Cell Ph # _____

Emergency Contact _____ Ph# _____

Primary Care Physician _____

Ph # _____

Referred By / How Did you Hear About Us?

Signature of Patient or Legal Guardian

Date

Print Name

NOTE: WBSSC will never sell your personal information or use it for solicitation purposes.

Willow Bend Sports & Spine Center Patient Intake Form

Name _____ Date _____

Date of Birth _____ Phone# _____

1. What is the “main” reason for your visit today? (Please limit each visit to ONE area of treatment) _____

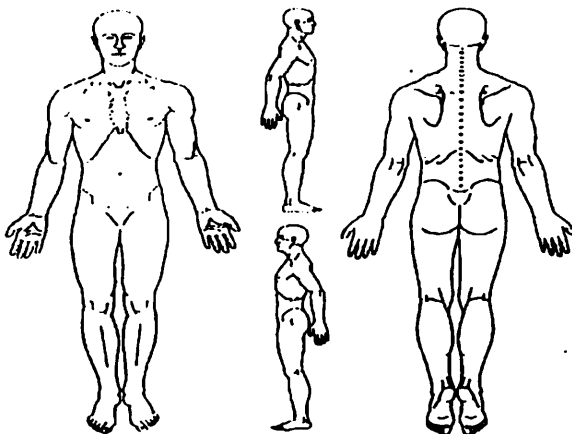
2. Please circle the severity of your main complaint

(None) 0 1 2 3 4 5 6 7 8 9 (Severe)

3. Please indicate your “overall” improvement of your condition since your initial visit.

No Change 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Using the diagram and symbols below, please indicate where you are experiencing your “main” complaint today



A=Aching **B=Burning**
C=Cramping **D=Dull**
N=Numbness **S=Sharpness**
P=Pins/Needles **ST=Stabbing**
T=Tightness

^^^=Shooting ///=Throbbing

+++ =Tingling

O=Other: _____

5. Please describe ALL details concerning your “main” complaint

**Willow Bend Sports & Spine Center
Patient History**

Patient Medications

(Please Include Vitamins, Supplements and Herbs)

_____	_____
_____	_____
_____	_____
_____	_____

Previous and Current Medical Conditions

(Please Include Hospitalizations and Surgeries)

_____	_____
_____	_____
_____	_____

Patient Allergies

(Please List ALL Medicine and Food Allergies)

_____	_____
_____	_____
_____	_____

Patient Family History

(Please List Any Medical Conditions)

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Grandmother(s) _____

Grandfather(s) _____

**Willow Bend Sports & Spine Center
Patient History (Continued)**

Patient Current Symptoms and Past Care
(Please Circle Yes or No)

Does the pain wake you up at night?	Yes	No
Does the pain radiate from one region to another?	Yes	No
Do you have noticeable weakness in any region?	Yes	No
Do you have any bladder issues because of your condition?	Yes	No
Have you had an MRI, X-Ray, CT Scan, or Bone Scan for your condition(s) within the last year?	Yes	No

If yes, what is the name of the imaging facility? _____

Patient Social History

Patient Work History (circle one)

EMPLOYED UNEMPLOYED RETIRED HOMEMAKER STUDENT

Patient Occupation (Please describe the environment in which you work)

Alcohol Yes No If yes, I have ____ drink(s) per day or ____ drink(s) per month.

Tobacco Yes No If yes, I smoke ____ pack(s) per day or ____ pack(s) per month.

Illegal Drugs Yes No If yes, what substance? _____

Signature of Patient or Legal Guardian

Date

Willow Bend Sports & Spine Center

Patient HIPPA & Privacy Practices Authorization

Name _____

Consent for Treatment I hereby authorize the doctor(s) at Willow Bend Sports & Spine Center and their staff to perform diagnostic tests and provide the necessary treatment for chiropractic/medical and health care for the above-mentioned patient.

Patient Privacy Practices Willow Bend Sports & Spine Center is committed to ensuring your Protected Health Information (PHI), governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), remains confidential. All electronic and paper medical records are safeguarded and released only with your consent to your insurance carrier (should you file with your insurance provider), medical professionals directly involved with your care, or as required by law.

I have been informed of and given the opportunity to review and secure a copy of Willow Bend Sports & Spine Centers' Notice of Privacy Practices, containing a complete description of the uses and disclosures of my protected health information. I understand the Notice of Privacy Information serves as:

1. A basis for planning my care and treatment.
2. A means of communication amongst health care professionals who contribute to my care.
3. A source of information for applying diagnosis and surgical information to my bill.
4. A means by which a third-party payer can verify services billed were provided.
5. A tool for routine health care operations, such as assessing care quality and reviewing the competence of health care professionals.

I have read and understand the Patient Privacy Practices provided by Willow Bend Sports & Spine Center. I understand my personal health information will be used in treatment and to improve the quality of care.

I authorize the release of my "Medical Records/Privacy Information", which includes protected health information (PHI), any medical conditions and billing/financial information to be disclosed for purposes of communicating results, findings, and care decisions to the following individuals:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Signature of Patient or Legal Guardian

Date

**Willow Bend Sports & Spine Center
Office Policies**

Name: _____

Financial Responsibility: I understand Willow Bend Sports & Spine Center is a Self pay provider/office, and payment in full is due at the time of service.

Insurance: I understand Willow Bend Sports & Spine Center is Not "in network" with any insurance providers and does not guarantee insurance reimbursement. I understand, I will be furnished a detailed document of medical services performed during my appointment at checkout. I am aware it is my responsibility to retain all receipts required and I am solely responsible for filing insurance and am not guaranteed insurance reimbursement.

Cancellation: Rescheduling, and No Show Policy: A fee of \$195 for an existing patient and \$290 for new patient appointments will be charged to the credit card on file if I cancel, reschedule, or no show with less than 24-hour's notice during the week. I understand if no credit card number is on file, I will be required to pay the fee/s before I can schedule any future appointments.

Late Arrival Policy: I understand if I arrive 15 or more minutes past my scheduled appointment time, I may be asked to reschedule my appointment to another date/time.

Walk In Appointment Policy: I understand walk in appointments are not available.

Medical Form(s) Requests: I understand Willow Bend Sports & Spine Center may require up to seven (7) business days to complete medical form requests.

Medical Record Copies: I understand a fee of \$30 will be assessed for all copies of medical reports. There is No Fee to fax or email medical reports to continuing care provider referrals. Note: A "medical Records Release" must be signed by the patient, or guardian, and submitted to our office prior to the processing of any records.

Patient Termination Policy: I understand Willow Bend Sports & Spine Center may require reserves the right to terminate treatment and care at the doctor or staffs' discretion. Common reasons include but are not limited to 1. Use of foul language:2. Chronic non-compliance of recommended treatment: 3. Abusive behavior toward the doctor, staff, patients, or visitors. 4. Chronic late arrival or appointment no-shows.

I have read and understand the office policies of Willow Bend Sports & Spine Center, the office of Jeff Eidsvig, DC, PLLC.

Signature of Patient or Legal Guardian

Date

**Willow Bend Sports & Spine Center
Office Policies (Continued)**

PATIENT NAME _____

**NAME ON CREDIT
CARD** _____

**CREDIT CARD
NUMBER** _____

**EXPIRATION
DATE** _____

CVV _____

ZIPCODE _____

Signature of Patient or Legal Guardian

Date