PATIENT INFORMATION FORM

Name: _____ Today's Date: ____/____/_____

Social Security Number ☐☐☐☐☐☐☐☐☐ Birth Date: ____/____/_____ Age: _____ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ____/____/_____ Phone: (_____) _____

Mother: _____ Date of Birth: ____/____/_____ Phone: (_____) _____

Guardian: _____ Date of Birth: ____/____/_____ Phone: (_____) _____

Who do you normally live with? ☐Mother & Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of These

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

E-mail Address _____

Phone (_____) _____ Cell Phone (_____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐FULL-TIME ☐PART-TIME

Name of Spouse _____ Spouse's Date of Birth ____/____/_____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is student at _____ ☐FULL-TIME ☐PART-TIME

Who should we contact in the event of an emergency? _____ Phone: (_____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐YES ☐NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐YES ☐NO

Did it result from a *work-related* accident or cause? ☐YES ☐NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately when did your injury or condition occur? ____/____/_____

PATIENT INFORMATION FORM

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or a similar condition? ☐YES ☐NO If yes, when and describe : _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

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Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Date of last physical examination? ____/____/_____

What operations have you had? _____ When? ____/____/_____

Serious illnesses or conditions? _____ When? ____/____/_____

Have you been treated for any health condition by a physician in the last year? ☐YES ☐NO

Describe: _____

What medications or drugs are you taking? _____

Do you have health insurance? ☐YES ☐NO Company: _____

Full name of policy holder: _____ Policy Holder's D.O.B. ____/____/_____

Does the policy holder have the insurance through his/her employer? ☐YES ☐NO

If yes, who is the employer? _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I agree to pay my estimated co-pay at the time services are rendered, including any deductibles, and further understand that the estimated co-pay is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual co-pay as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account. I understand that an interest charge at the annual rate of 18% will appear on accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney(s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/_____

Dr. Charles V. Judge III, D.C.
TOTAL HEALTH CHIROPRACTIC
Phone: (301) 645-5393
Fax: (301) 645-9490
www.waldorfchiropractic.com

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I authorize any insurance carrier to pay directly to my physicians such sums as may be due and owing to them. If I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any medical insurance, personal injury protection, and medical payment coverage, I agree to immediately make payment to you upon receipt of those monies.

I further irrevocably assign to you, and authorize and direct my attorney(s), if applicable, to pay from the proceeds of any settlement, judgment or insurance policy, all reasonable fees for health care services, equipment, supplies, preparation of reports, and testimony provided by you as a result of the injury or condition sustained on the date of accident. I understand that This in no way relieves me of my personal primary responsibility to pay for such services, and that the signing of this form does not prohibit customary billing by you. I further understand that my responsibility to you for payment is not contingent on any settlement, judgment or verdict.

I do hereby authorize the above facilities to furnish my attorney(s) any and all medical information, bills, and records which they may request to all illnesses and injuries suffered by me, my wife, my husband, or children including, but not limited to, the injuries sustained on the date of accident identified below.

It is further understood that the statute of limitations in this State is three (3) years from the time services were last performed. I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date, which is beyond the three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for fees for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

I further authorize my attorney(s) upon your request to notify you of any substantial change in the status of the cause of action related to the illness or injuries described above which would affect my ability to pay for the health care services rendered. I further authorize and direct my attorney(s) to notify you should their representation of my interests in connection with the illnesses and injuries be terminated for any reason.

A photocopy of this Authorization shall be binding as the original.

Patient Name (Printed): _____

Patient's Signature: _____ Date Signed: _____

Patient Address: _____

_____

The undersigned attorney for the patient referred to above hereby agrees to comply fully with the foregoing "Authorization of Assignment" and agrees to advise the named assignee, the medical group referred above, in writing of the status of the claim of the above named patient within ten (10) days of any request.

Attorney Name (Printed): _____

Attorney Signature: _____ Date Signed: _____

Address: _____

_____

Phone Number: (_____)_____-_____

Attorney's Case Number: _____

PATIENT AGREEMENT

I, the undersigned, have insurance coverage with _____
(NAME OF INSURANCE COMPANY)
and assign directly to Dr. Charles V. Judge III, D.C. all medical 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 my insurance submissions.

_____ _____

SIGNATURE OF INSURED/GUARDIAN **TODAY'S DATE**

Dr. Charles V Judge III, D.C.
Total Health Chiropractic
3 Post Office Road, Suite 104
Waldorf, MD 20602

CONSENT FOR TREATMENT

I, the undersigned, or authorized individual acting on behalf of the patient, agree and give my consent for Dr. Charles Judge (Total Health Chiropractic) to administer medical care and treatment to (Print Name)_____ considered necessary and proper in the diagnosis and treatment of the patient.

Patient/Parent/Guardian _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or physical therapy benefits to which I am entitled, including Medicare, private insurance, and any other health plans directly to Dr. Charles Judge (Total Health Chiropractic). A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Parent/Guardian _____ Date _____

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Dr. Charles Judge (Total Health Chiropractic) to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our notice of Privacy Practices provides more detailed information on how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices before you sign your consent and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of revised notice by contacting us at 301-645-5393. You have a right to request that we restrict how we use your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do agree to grant your request, we are bound by that agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

Patient/Parent/Guardian _____ Date _____

Dr. Charles V Judge III, D.C.
Total Health Chiropractic
3 Post Office Road, Suite 104
Waldorf, MD 20602

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance company as a "courtesy" to you, although you are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment, the balance will be due in full from you within 30 days. If payment subsequently is made by your insurance carrier in excess of the balance on your account, we will promptly refund the credit.

It is our policy to collect co-payments and deductibles at the time services are rendered if your insurance company or third party payer requires such.

APPOINTMENT POLICY STATEMENT

1. Multiple appointments have been scheduled as part of your treatment plan to both assure quality care and incorporate those appointments that best meet your schedule.
2. It is of utmost importance that you stay on your scheduled plan. Therefore, if you are unable to keep your appointment for any reason, we require that you call to reschedule your visit for the same week.

I have carefully read the above information and understand my responsibility for the payment of my account.

Patient/Parent/Guardian _____ Date _____

Patient Name _____ **Date** _____ **Doctor's Int.** _____

GENERAL SYMPTOMS

Check symptoms you currently have or have had in the past.

GENERAL
- ☐ Bruise Easily
- ☐ Chills
- ☐ Dental Problems
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight Gain

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other

Date of last menstrual period: _____

Date of last Pap Smear: _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of Children _____

CONDITIONS

Check conditions you have or have had in the past.

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

FAMILY HISTORY

List any of the conditions listed above that another family member has had. _____

_____

SOCIAL HISTORY

Emotional Stress	☐ Heavy	☐ Moderate	☐ Light	Hours per day _____
Physical Work	☐ Heavy	☐ Moderate	☐ Light	Hours per day _____
Exercise	☐ Heavy	☐ Moderate	☐ Light	Hours per week _____ Type _____
Smoking	☐ Current	☐ Previous	☐ Packs/Day _____	No. of Years _____
Alcohol	☐ Heavy	☐ Moderate	☐ Light	Times per week _____