Bridgeman Chiropractic PLLC

304 S. Water St., Suite 103
Ellensburg, WA 98926
509.925.7246
925PAIN.com

D.M.Bridgeman, D.C. & D.B.Bridgeman, D.C.

We specialize in assisting you to achieve an optimal level of pain free health through our specialized pain relief method. We combine chiropractic, ART, accelerated rehabilitation, massage therapy, and nutrition to provide our patients with a faster, long-lasting treatment. We will help reveal areas of spinal dysfunction through examination and any needed digital x-rays (omitting half the radiation). Then, we offer a care plan designed to give you the best results in the shortest amount of time. Your results will be attained through a strict adherence to the treatment recommendations. This will allow you to achieve superior results.
Please feel free to ask any questions at any point, we look forward to serving you.

PATIENT INFORMATION

Today's Date: ____________ Sex: o Male o Female
Full Name: ____________ SS#: ____________
Address: ____________ Birth date: ____________
City, State, Zip: ____________ Home phone: ____________
Where do you prefer to receive calls? ____________ Work Phone: ____________
Your employer: ____________ Cell Phone: ____________
Occupation: ____________ Cell Provider: ____________
Email address: ____________
Are you: o a Minor o Single o Married o Divorced o Widowed o Separated
Name of Spouse: ____________
Emergency Contact: ____________ Phone: ____________
Primary Care MD: ____________ Phone: ____________
Whom may we thank for referring you to us? ____________

**** If this is a worker's compensation case or a motor vehicle accident, please stop and inform the receptionist.***

INSURANCE INFORMATION

Responsible Party (Insurance Subscriber)
Name of person responsible for this account: ____________
Address: ____________ Phone: ____________
City, State, Zip: ____________ Birth date: ____________
Relationship to patient: ____________

Notice: All first visit charges are payable when services are rendered. The fee paid for x-rays is for professional analysis only. The films themselves remain the property of this office. The patient may check out X-ray films, however, as one does books from a library.
As a courtesy to you, this office will *verify* insurance coverage for you. Please make sure we have your current insurance card. We do file Insurance claims for you.

Primary Complaint: ______________________________

When did it start? ______________________________

How did your main problem appear? o Gradually o Suddenly o Accident/trauma o Unsure

How frequent do you experience pain? o 100% o 75% o 50% o 25% o Less than 25%

Is your problem getting? o Better o Worse o Staying the same

Does anything make it feel -better? ______________________________

-worse? ______________________________

When is your problem most severe? o Morning o Day o Evening o Night

Does your problem keep you from? o Working o Sleeping o Your Daily Routine o Recreation

Type of pain: o Throbbing o Dull o Sharp o Numbness o Aching o Shooting o Burning

o Tingling o Cramping o Swelling o Other: ______________________________

- Place indicate the severity of your pain or discomfort - No Pain 2 3 4 5 7 8 9 Extreme

Second Complaint: ______________________________

When did it start? ______________________________

How did your main problem appear? o Gradually o Suddenly o Accident/trauma o Unsure

How frequent do you experience pain? o 100% o 75% o 50% o 25% o Less than 25%

Is your problem getting? o Better o Worse o Staying the same

Does anything make it feel -better? ______________________________

-worse? ______________________________

When is your problem most severe? o Morning o Day o Evening o Night

Does your problem keep you from? o Working o Sleeping o Your Daily Routine o Recreation

Type of pain: o Throbbing o Dull o Sharp o Numbness o Aching o Shooting o Burning

o Tingling o Cramping o Swelling o Other: ______________________________

- Place indicate the severity of your pain or discomfort - No Pain 2 3 4 5 7 8 9 Extreme

Additional Complaint: ______________________________

When did it start? ______________________________

How did your main problem appear? o Gradually o Suddenly o Accident/trauma o Unsure

How frequent do you experience pain? o 100% o 75% o 50% o 25% o Less than 25%

Is your problem getting? o Better o Worse o Staying the same

Does anything make it feel -better? ______________________________

-worse? ______________________________

When is your problem most severe? o Morning o Day o Evening o Night

Does your problem keep you from? o Working o Sleeping o Your Daily Routine o Recreation

Type of pain: o Throbbing o Dull o Sharp o Numbness o Aching o Shooting o Burning

o Tingling o Cramping o Swelling o Other: ______________________________

- Place indicate the severity of your pain or discomfort - No Pain 2 3 4 5 7 8 9 Extreme

Have you seen another health professional for the primary, second, and additional conditions?

o No o Chiropractor o Medical

Name and city of other doctor(s) who have treated you for your condition: ______________________________

____

Difficult activities: o Sitting o Laying down o Standing o Walking o Bending o Other

Health History: Please check all that apply to you; things that you have now or in the past.

o Hypoglycemia	o Anxiety	o Arthritis
o Epilepsy	o Cardiac problems	o Low Blood Pressure
o High Blood Pressure	o Dizziness/ vertigo	o Prostate problems
o Respiratory problems	o Loss of consciousness	o Eye problems
o Headaches	o Digestive Problems	o Fatigue
o Depression	o Fractures	o Hearing problems
o Diabetes	o Hormonal problems	o Kidney stones
o Cancer	o Other: ______	

Date of Last Physical Exam: ______

Please list any surgeries and the dates they occurred: ______

______

Please mark medications you are currently taking: o None o Anti-inflammatory
o Pain Killers o Muscular Relaxants o High Blood Pressure o Diabetes

What vitamins/supplements do you currently take? ______

Daily Habits:

Do you exercise? o No o Yes

What do your daily work habits include? o Sitting o Standing o Moving o Heavy Labor
o Driving o Computer work o Other: ______

Do you smoke? o No o Yes - How much per day? ______

How much alcohol do you consume on a weekly basis? ______

How much caffeine do you consume on a daily basis? ______

Women Only:

Are you pregnant? o Yes o No

______
Signature Date

HIPAA - Notice of Privacy Practice Acts

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to: - conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly – Obtain payment from third party payers. I understand that I may ask to receive a more complete description of the uses and disclosure of my health information. (Please see the front desk if you would like more information on how to obtain the full document)

______ ______
Patient Signature Date

Consent to Evaluate and Adjust a Minor - Parents or Guardians:

I hereby grant permission to Bridgeman Chiropractic PLLC to perform any necessary tests on my minor child, and to render care for said child. I acknowledge that I am the parent or legal guardian of the child listed on this form.

______ ______
Signature **Date**

AUTHORIZATION and Financial Agreement:

I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered. I understand that providing incorrect or inaccurate answers can be harmful to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or to me during the course of such chiropractic care to third party payers and/or healthcare practitioners. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I understand that any explanation of my insurance coverage provided to me is only a ***QUOTE*** *from my insurance company and is not a guarantee of payment. I also understand that Bridgeman Chiropractic PLLC bills my insurance as a* ***COURTESY*** *and if my insurance chooses not to pay for whatever reason, I will be responsible for the remainder.*

Signature of patient ____ **Date** ______________

(or parent or guardian if a minor)

PATIENT'S CONSENT

I, ____, hereby grant Bridgeman Chiropractic PLLC permission to call my (please circle those that apply) home, cell, and work numbers, and/or email me for appointment reminders and routine office needs regarding my account. I hereby **consent** for Bridgeman Chiropractic PLLC to leave any messages for appointments, changes in schedule, and routine office needs with the following family members:

Name: Relation:

Name: Relation:

I hereby **deny** permission for any information to be given to the following family members regarding any routine office needs here at Bridgeman Chiropractic PLLC:

Name: Relation:

Name: Relation: