Wieging Physical Medicine, LLC

3435 Farm Bank Way Grove City, Ohio 43123
(614) 539-0405 (p) - (614) 539-0554(f)

Acct # _____

Confidential Patient Information

Patients Name: _____ Sex [ ] M [ ] F Age: _____

Address: _____ Marital Status: Married [ ] Single [ ] Divorced [ ]

City: _____ Zip: _____ Widowed [ ] Separated [ ]

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ Social Security #: _____

Email: _____

Occupation: _____ Employer/School: _____

How did you hear about our office? Referred By?

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder Birth date: _____

Policy Holder Employer: _____ Policy Holder SS#: _____

Patients relationship to the policy holder: [ ] Self [ ] Child [ ] Spouse

Secondary Ins. Company: _____ Ins. Phone # _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder Birth date: _____

Policy Holder Employer: Policy Holder SS#: _____

Family Physician: _____ Physician's Phone _____

Physician's address _____

Person to contact in case of emergency (Name& Phone #): _____

Have you ever been under Chiropractic Care? (Y / N) If so, with who? _____

What is your goal in our office? _____

What is/are your Chief Complaint(s)? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Wieging Physical Medicine, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered at above clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor/clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor/clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor/clinic to release any and all medical information to other health care providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

I may be personally billed $20-$40 for missed massage or physical therapy appointments when I do not provide 24 hour notice of cancellation.

I have read and fully understand this agreement.

_____ _____

Signature Date

Wieging Physical Medicine, LLC

Updated Health History

Have you received any of the following treatments for your condition?
Chiropractic *Physical Therapy* *Medication* *Surgery* *Other:* _____

Date of last (MO/YR) Physical Exam ___/___ Spinal Exam ___/___
Blood Test ___/___Urinalysis ___/___ MRI/CT/Xray ____/___

Have you had any of the following? Circle "Y" to indicate YES or "N" to indicate NO:

AIDS/HIV	Y	N	Herniated Disc	Y	N	Rheumatoid Arthritis	Y	N
Appendicitis	Y	N	Herpes	Y	N	Stroke	Y	N
Arthritis	Y	N	High Cholesterol	Y	N	Thyroid Problems	Y	N
Asthma	Y	N	Kidney Disease	Y	N	Tonsillitis	Y	N
Bleeding Orders	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Bronchitis	Y	N	Migraines	Y	N	Tumors/Growths	Y	N
Cancer	Y	N	Miscarriage	Y	N	Typhoid Fever	Y	N
Diabetes	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N
Emphysema	Y	N	Osteoporosis	Y	N	Implants (Medical/Electrical/Mechanical)	Y	N
Epilepsy	Y	N	Pacemaker	Y	N			
Fractures	Y	N	Parkinson's	Y	N	Head Injuries	Y	N
Gout	Y	N	Pinched Nerve	Y	N	Broken Bones	Y	N
Heart Disease	Y	N	Pneumonia	Y	N	Surgeries	Y	N
High Blood Pressure	Y	N	Polio	Y	N	Other Surgeries/Illnesses:	Y	N
Hepatitis	Y	N	Prosthesis	Y	N			
Hernia	Y	N	Psychiatric Care	Y	N			

Additional pertinent health information: _____

Exercise: None Light Moderate Heavy
Habits: *Smoking* N / Y :_____per day *Alcohol* N / Y :_____per day *Coffee/Caffeine* N / Y_____ Per day
Are you pregnant: N / Y If yes, due date_____

Accident Information:

Is this condition due to an accident? YES NO If yes, type? AUTO WORK HOME OTHER
To whom have you made a report? _____ Claim #_____
Insurance Company_____ Insurance Phone #_____
Attorney Name _____Attorney Phone #_____

Medications:	**Allergies:**	**Vitamins/Herbs/Minerals:**

Print Name:_____ Signature:_____ Date:_____