GANTOS
CHIROPRACTIC CENTER, P.C.

David J. Gantos, D.C.

6045 Corunna Rd., Ste A
Flint, MI 48532
(810) 733-5211

Patient Information Case # _____

General Information

Patient Last Name: _____ **First**: _____

Address: _____ **City**:_____

State: _____ **Zip**: _____ **Birthday**: ____/____/_____ **Gender**: F / M **Social Security**: _ _ _ /_ _ /_ _ _ _

□ Married □ Single □ Widowed □ Divorced

Home Phone: _____ **Cell Phone**: _____

Would you like text reminders? Yes/No Phone Carrier: _____

Signature: _____

Employment: □ Full Time □ Part Time □ Not Employed □ Retired

Employer's Name _____Occupation _____

EMPLOYED Address _____ City _____

State _____ Zip Code_____ Phone _____

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

Spouse's Employer _____

Referred By: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Phone Number: _____

Insurance

Release of Insurance use: Dr. David Gantos may use my health care and insurance information and may disclose such information to my Insurance Provider and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Patient Name: _____ Date:_____

Signature: _____

Accident Information Is this condition due to an accident? □ Yes □ No

Type of accident: □ Auto □ Work □Home □Other _____

To whom have you made a report regarding this injury to? □ Auto Company □ Work Comp. □ Employer □ Other

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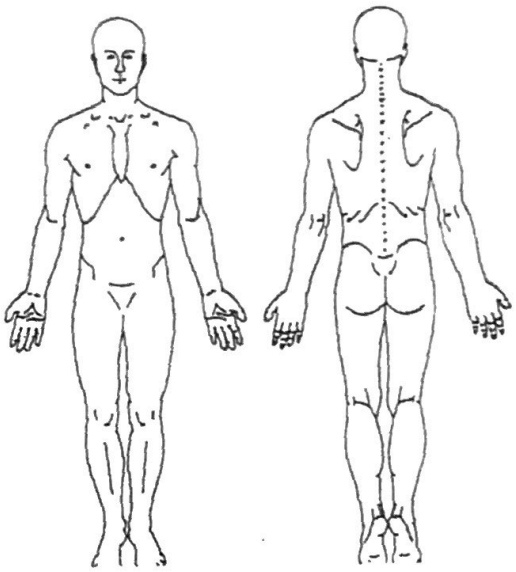
Name: Date: PATIENT INITIAL

What is your chief complaint ?

_____

Indicate the location of the pain or problem:

Instructions: On the body diagrams to the right, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



Quality: How would you describe the pain or symptom ?
(Circle all that apply)

Aching	Dull	Pulsating	Stabbing	Tightness
Burning	Excruciating	Radiating	Stiffness	Weakness
Cramping	Numbness	Sharp	Throbbing	
Diffuse	Pounding	Shooting	Tingling	

Severity: On a scale of 0 to 10, with 10 being the worst possible, how would you rate your pain or problem ?

Now:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10
At it's best:	0	1	2	3	4	5	6	7	8	9	10
At it's worst:	0	1	2	3	4	5	6	7	8	9	10

Onset: Describe how and when it began: _____

_____

_____

How often are you experiencing it ? (Circle one)

Infrequently	Occasionally	Intermittently	Frequently	Constantly
(less than daily)	(1/4 of the time)	(1/2 of the time)	(3/4 of the time)	(90-100% of the time)

What makes it better ? (Circle all that apply)

Activity	Massage	Pain meds	Nothing
Heat	Standing	Sitting	Immobilization
Ice	Walking	Stretching	
Elevation	Resting	Movement	

Other: _____

What makes it worse ? (Circle all that apply)

Pushing	Bending	Kneeling	Nothing
Pulling	Sitting	Lying down	Weight bearing
Movement	Standing	Coughing	Looking up
Driving	Lifting	Sneezing	Looking down

Other: _____

Describe any other symptoms related to this problem: _____

_____

_____

What have you done for this problem before coming in today ? (Circle all that apply)

Bed rest	Massage	Exercise	Nothing
Heat	Pain meds	Hot showers	Topical Ointment
Ice	Traction	Chiropractic	Family MD

Other: _____

What functional activities are affected by this problem ? _____

_____

_____

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NAME: _____ HEIGHT: _____ WEIGHT: _____ PATIENT INITIAL _____

PREVIOUS ILLNESSES AND MAJOR INJURIES

PLEASE LIST ANY PREVIOUS ILLNESSES AND MAJOR INJURIES:

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

SURGERIES AND HOSPITALIZATION

PLEASE LIST ANY SURGERIES AND HOSPITALIZATIONS:

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

Year _____ Type _____ Residual problem _____

MEDICATIONS AND SUPPLEMENTS

PLEASE LIST ALL MEDICATIONS, NUTRITIONAL SUPPLEMENTS(S), VITAMINS(V), AND OVER THE COUNTER DRUGS(OTC):

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

Medication _____ Milligrams/day _____ S,V,OTC _____ Milligrams/day _____

ALLERGIES

PLEASE LIST ALL KNOWN ALLERGIES:

_____

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

HAS ANY RELATIVE EVER HAD THE FOLLOWING? (Please circle)

HEART PROBLEMS	Father	Mother	Sister	Brother	Other
HIGH BLOOD PRESSURE	Father	Mother	Sister	Brother	Other
ARTHRITIS	Father	Mother	Sister	Brother	Other
DIABETES	Father	Mother	Sister	Brother	Other
STROKE	Father	Mother	Sister	Brother	Other
CANCER	Father	Mother	Sister	Brother	Other
OSTEOPOROSIS	Father	Mother	Sister	Brother	Other
BLOOD CLOTS	Father	Mother	Sister	Brother	Other

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed

Employment status: ☐ Employed ☐ Homemaker ☐ Self employed ☐ Retired ☐ Unemployed ☐ Student

Domicile: ☐ Live alone ☐ Live with spouse ☐ With parents ☐ With children ☐ Assisted living

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously, but quit_____ ☐ Current packs/day_____

Use of drugs: ☐ Never ☐ Type/frequency _____

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CHIROPRACTIC CONSENT FOR CARE

INFORMED CONSENT FOR CHIROPRACTIC CARE:

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority for examination and to care for them in accordance with chiropractic test, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformation or pathologies may render them susceptible to injury. Even though a procedure was performed correctly, it must be understood by any patient seeking health care, no guarantee of results can be made, and that injury, paralysis, or death may occur from any procedure performed, and by signing this consent for care form, I acknowledge the risk or danger and choose to have chiropractic procedure performed. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through heath care procedures whenever he/she is suffering from: Latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, they are not medical specialist. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition.

CHIROPRATIC

It is important to acknowledge the difference between the health care specialties of chiropractic, and traditional medicine. Chiropractic care sees to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes physical and spinal conditions. A doctor of chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When such VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

RESULTS

The purpose of chiropractic service is to promote natural health through the reduction of VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is immediate. In other cases, it is gradual. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic procedure. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not, respond to chiropractic care, may come under the control or be helped medical science. The fact is that the science of chiropractic care may never be so exact as to provide definite answers to all problems.

TO THE PATIENT

Please discuss any questions or concerns with the doctor before signing this statement of consent. I have read and understand the foregoing and give my consent to proceed with chiropractic care.

X _____ X _____

Signature Date

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Gantos Chiropractic Center as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care.

We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.

Patients are responsible for payment of co pays, coinsurance, deductibles and all other procedures or treatments not covered or approved by THEIR insurance plan.

Co pays are due at the time of service.

Coinsurance, deductibles, and non-covered items are due 30 days from receipt of billing.

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Gantos Chiropractic Center* will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to *Gantos Chiropractic Center*. I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable at that time.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ (print name) have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
-Obtain payment for third-party payer.
-Conduct normal health care operations.

_____
Patient Name

_____
Signature

_____
Date