Welcome to our Practice

Name: _____ Date: _____

Last First MI

Email Address: _____

Phone: (H) _____ (C) _____

Mailing Address: _____City: _____ Zip: _____

Date of Birth: Month: _____ Day:_____ Year: _____

Social Security Number: _____

How did you hear about our practice? _____

Marital Status: Single Married Divorced Widowed Separated

Do you have any children? Yes or No If yes how many do you have?_____

Do you exercise and how often?

Frequently Occasionally Never

What is your daily or weekly intake of the following?

Caffeine: _____ cup a day Alcohol _____ drink per week Cigarettes_____ pack

There is a possibility that I may be pregnant at this time.

- □ Yes, I am definitely pregnant.
- □ No, I am definitely not pregnant at this time. The date of my last menstrual period was: _____

Employer /Employment Status □Employed □Unemployed □Full Time / □Part Time Student □Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (_____) _____-_____ Type of Work:_____

Is it ok to contact you at work? □ Yes □ No

Emergency Contact Information

Name: (*First*) _____ (*Middle*)_____(*Last*)_____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

☐ Yes ☐ No

Who besides yourself is responsible for your bill? ☐Self-Pay ☐Health Insurance ☐Medicare ☐Auto Insurance

☐ Other (*Be Specific*): _____

Personal Health Insurance Carrier: _____ Health ID Card _____

Insured Person's Name: _____ Group #: _____

Auto Insurance Carrier & Claim #: _____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____

_____

_____

_____

LIST ANY PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____

_____

_____

_____

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?

Please explain in the following section any information that you feel would be helpful to the doctor.

_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:
I authorize payment of medical benefits to Touchstone Chiropractic for services rendered to me.

REIMBURSEMENT POLICY:
We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:
I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

_____
PATIENT PRINTED NAME

_____

PATIENT SIGNATURE

_____
DATE

REVIEW OF SYSTEMS

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

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
□**None**
Chills□
Daytime Drowsiness□
Fatigue□
Fever□
Night Sweats□
Weight Gain□
Weight Loss□

Eyes/Vision:
□**None**
Blindness□
Blurred Vision□
Cataracts□
Change in Vision□
Double Vision□
Eye Pain□
Field Cuts□
Glaucoma□
Itching□ *(around the eyes)*
Photophobia□
Tearing□
Wears Glasses or Contacts□

Ears, Nose and Throat:
□**None**
Bleeding□
Dental Implants□
Dentures□
Difficulty Swallowing□
Discharge□
Dizziness□
Ear Drainage□
Ear Infection□*(s)*
Ear Pain□
Fainting□
Headaches□
Head Injury□ *(history of)*
Hearing Loss□
Hoarseness□
Loss of Smell□
Nasal Congestion□
Nose Bleeds□
Post Nasal Drip□
Rhinorrhea□ *(runny nose)*
Sinus Infections□
Snoring□
Sore Throats□
Tinnitus□ *(ringing in the ears)*
TMJ Disorder□

Cardiovascular:
□**None**
Angina□ *(chest pain or discomfort)*
Chest Pain□
Claudication□ *(leg pain or achiness)*
Heart Murmur□
Heart Problems□
Orthopnea□ *(difficulty breathing while lying)*
Palpitations□ *(irregular or forceful heart beat)*
Paroxysmal Nocturnal□ Dyspnea *(shortness of breath at night)*
Shortness of Breath□
Swelling of Leg□*(s)*
Ulcers□
Varicose Veins□

Gastrointestinal:
□**None**
Abdominal Pain□
Belching□
Black, Tarry Stools□
Constipation□
Diarrhea□
Difficulty Swallowing□
Heartburn□
Hemorrhoids□
Indigestion□
Jaundice□ *(yellowing of the skin)*
Nausea□
Rectal Bleeding□
Abnormal Stool Caliber□ *(quality)*
Abnormal Stool Color□
Abnormal Stool□ Consistency
Vomiting□
Vomiting Blood□

Respiration:
□**None**
Asthma□
Coughing up blood□
Shortness of Breath□
Sputum Production□
Wheezing□

Endocrine:
□**None**
Cold Intolerance□
Diabetes□
Excessive Appetite□
Excess□ive Hunger
Excessive Thirst□
Frequent Urination□
Goiter□
Hair Loss□
Heat Intolerance□
Unusual Hair Growth□
Voice Changes□

Skin:
□**None**
Changes in Nail Texture□
Changes in Skin Color□
Hair Growth□
Hair Loss□
Hives□
Itching□
Paresthesia (numbness,□ prickling, or tingling)
Rash□
History of Skin Disorders□
Skin Lesions or Ulcers□
Varicosities□

Nervous System:
□**None**
Dizziness□
Facial Weakness□
Headaches□
Limb Weakness□
Loss of Consciousness□
Loss of Memory□
Numbness□
Seizures□
Sleep Disturbance□
Slurred Speech□
Stress□
Strokes□
Tremors□
Unsteadiness of Gait□

Allergy:
□**None**
Anaphylaxis□ *(history of)*
Food Intolerance□
Itching□
Nasal Congestion□
Sneezing□

Hematology:
□**None**
Anemia□
Bleeding□
Blood Clotting□
Blood Transfusion□*(s)*
Bruises easily□
Fatigue□
Lymph Node Swelling□

Psychological:
□**None**
Anhedonia□ *(inability to experience joy or enjoy life)*
Anxiety□
Appetite Changes□
Behavioral Change□*(s)*
Bipolar Disorder□
Confusion□
Convulsions□
Depression□
Insomnia□
Memory Loss□
Mood Change□*(s)*

Female:
□**None**
Birth Control Therapy□
Breast Lumps / Pain□
Burning Urination□
Cramps□
Frequent Urination□
Hormone Therapy□
Irregular Menstruation□
Urine Retention□
Vaginal Bleeding□
Vaginal Discharge□

Male:
□**None**
Burning Urination□
Erectile Dysfunction□
Frequent Urination□
Hesitancy or Dribbling□
Prostate Problems□
Urine Retention□

Patient Signature: _____

FOR OFFICE USE ONLY: I have reviewed the above ROS with the above named patient:
Doctor Signature _____ Date _____

Family Health History

Occasionally, a patient's health problems and treatment response are affected by hereditary or family related spinal weaknesses. Please help us to better understand your spine and how you might respond to treatment by completing the information below for all family members.

Patient Name: _____

ILLNESS	SPOUSE	FATHER	MOTHER	CHILD	CHILD	CHILD	OTHER FAMILY	OTHER FAMILY
Allergies								
Arm/Hand Pain								
Arthritis								
Asthma								
Diabetes								
Dizziness								
Ear Aches/Ringing								
Hand Pain								
Leg Pain or Numbness								
Low Back Pain								
Low/high Blood Pressure								
Menstrual Difficulties								
Mid-Back Pain								
Muscle Cramps								
Neck Pains								
Nervousness								
Neuritis								
Respiratory Problems								
Sciatic								
Scoliosis								
Shoulder Pain								
Sinus								
Stiff Neck or Back								
Throat Problems								
Thyroid								
Tiredness								
Ulcers/Digestive								
Other								

Missed Appointment Policy

You agree to give us the courtesy of a phone call if you need to miss your appointment. It also states that you will try to reschedule your missed appointment the same week in order for us to help you either get out of pain or help you continue to make the spinal changes we are shooting for. Of course we understand that emergencies arise and you are not able to call immediately. We ask that you call or email us at some point during the day to let us know.

We ask that you understand that when you miss an appointment and do not tell us that you are not coming, that takes up an appointment slot for someone who is in need of our care. If you fail to call or email Dr. Zuniga's office to let us know that you will not be able to make your appointment as scheduled this will result in a **$25 charge**.

There are two ways that you can get in touch with us during the day. One is calling us at 908-810-7424. The second way is emailing us at touchstonechiro@gmail.com. The email is monitored throughout the day and evening.

If you have any questions, please feel free to ask.

_____ _____

Patient Signature Date

OFFICE POLICY

The purpose of this patient office policy is to allow us to better serve you and to get the best results in the shortest period of time. It is our experience that those who adhere to the following policies get the best results.

Signing In
When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order you signed in. Other patients may be called before you because of the particular services being received that day or their doctor may be available before yours. When you go to the assigned treatment room, rest, relax and the doctor will be in as soon as possible.

New Injuries
In the event you sustain a new injury, please let the front desk coordinator know as soon as possible. There may be additional paper work to be filled out.

Appointments
After your visit, please see the front desk coordinator to make or confirm your next appointment.

New Patient Health Orientation
We recommend all patients attend our New Patient Health Orientation. This explains how the body functions, how chiropractic works and most importantly, how you can expedite the healing process. Family and friends are encouraged to attend.

Payment of Bills
We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our office manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect you to call your insurance company and help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.

Rescheduling Appointments
We set up specific treatment schedules for our patients. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time. If the same day is not possible, be sure to make up the missed appointment within one week.

Progress Evaluations & Re-examinations
Progress evaluations & re-examinations will be performed periodically to determine your rate of progress and future course of treatment. There is a fee for all progress evaluations. A special time will be set up for your re-evaluation appointments.

Upsets
We are here to serve you. Please speak with the staff or doctor about anything that could be upsetting you (e.g., long waits, treatment confusion). We see your comments as helping us to help you and others.

I, have read, understand and agree to the above patient office policy.

_____ _____

Patient Signature Date

Authorization for Release of Information to Family Members

Patient name: _____ Date of Birth:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Touchstone Chiropractic to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

***I do not wish to have Touchstone Chiropractic speak to anyone regarding my care or billing.**

Patient Signature: _____ Date: _____

Please list the phone number that you can best be reached at. Kindly indicate if you allow us to contact you via text message for appointment reminders.

Cell Phone: _____ Text reminder ok? YES NO

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature: _____ Date: _____

AUTHORIZATION FOR ASSIGNMENT & RELEASE

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

AUTHORIZATION FOR RELEASE OF INFORMATION:
I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:
I authorize payment of medical benefits to Touchstone Chiropractic/Dr. Zuniga for services rendered to me.

REIMBURSEMENT POLICY:
We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

_____
PATIENT PRINTED NAME

_____
PATIENT SIGNATURE

_____
DATE