Welcome!
Golden Sun Chiropractic Wellness Center, PLLC
PATIENT INFORMATION

Date of Visit: ________________ Chief Complaint: ____

Patient Name: ____ Age: _______ Date of Birth: ________________

Address: ____ City: ____________________ State: ______ Zip Code:_________

Home Phone: _(____)_______________________________ Cell phone: ____________________________ Sex (M/F): _____

Employer Name: ____ Work Phone: (_____)_______________

Student: Full-time _____ Part-Time _____ Name of School: ____

Marital Status: Married _____ Single _____ Widowed _____ Divorced ______ Other ______ E-mail address:_______________________

May we communicate with you via email___(Y/N) What time of day and phone number is best to reach you __________________________

Name of Spouse/Partner OR Parent: ____

Emergency Contact Name and Phone Number: ____

How did you find out about our office: Friend (name)________________________ Yellow Pages___ Web___Ad___Other______________

PAYMENT AGREEMENT:

- ❒ My insurance company is to be billed by Golden Sun Chiropractic Wellness Center, PLLC for my office visits. I understand that Golden Sun Chiropractic will bill my primary insurance first. I authorize my insurance company to send the payment for services rendered directly to Golden Sun Chiropractic. Whatever is not covered will then be billed to my secondary insurance. If I do not have secondary insurance OR my secondary insurance does not cover the remainder of the bill, I will pay for the remainder of the bill either in full or according to a payment plan established with Golden Sun Chiropractic Wellness Center, PLLC.
- ❒ I do not have insurance and will be paying at the time of each visit. I will receive a 20% discount when I pay at the time of each visit.
- ❒ I will pay for my visit(s) by credit card. Visa___MasterCard___ #______________________________Exp. Date_______________
- ❒ I will pay my balance due at the time of the visit. I will then submit the bill to my insurance company. Please give me a receipt.

Note: Minnesota State Law requires a 2% tax to be added to all charges.

Signature of agreement by patient/guardian to the above payment agreement:____

Dated this day of: ____________________________________

INSURANCE INFORMATION:

HMO _____ PPO _____ Worker's Comp _____ Auto _____ Group _____ Medicare _____ Medicaid _____ Other _____

Insured's Name (as it appears on the insurance card): ____Tel ______________________

Insured's Address (If same as patient put "same"): __________________________________City__________________State___Zip_______

Insured's Date of Birth: ____________Insurance Plan Name or Program Name: ____

Primary Insurance Company: ____

Address: ____City______________________State____Zip________Tel__________________

Insured's ID Number (or Claim Number if Auto/Work Comp):__________________________________ Group Number: _________________

Name of Claims Adjuster (if auto or work comp):_______________________Tel: ____________________Is there another benefit plan Y N

Secondary Insurance Company: _________________________________ Address____

Secondary Policy Number: _______________________________Secondary Group Number: ____________________ Tel:_______________

CONFIDENTIAL

Is your condition due to an accident (Yes or No): Auto _____ Home _____ Other _____ Explain ___________________________________

Date of accident: ________ Accident state ____ Is your condition a work related injury (Yes or No)________ Date of Injury: ___________

Do you have an Attorney (Yes or No)______Attorney's Name: ____

Address: ___________________________________City______________________State_____Zip__________Tel___________________

Are you on disability (Yes or No) Disabled from date: ____________________________ Disabled to date: ___________________________

Return to work date: _____________________ Did you require hospitalization (Yes or No) Hospital admit date: _______________________

Hospital discharge date: ______________ Is your condition due to illness (Yes or No) Have you had similar difficulties before (Yes or No):

If yes, date: _______________ Explain: ____

Have you ever had a traumatic injury or accident other than your present condition (Yes of No): _____ If yes, explain: __________________

____

Who is your Primary Care Doctor: _____________________________________ Address: _______________________________________

Phone: _(_____)____________________________________ Number of years with this doctor: ___________________________________

List names of any other doctors you have seen for present condition: (MD, DC, DO other)____

___________________________Results:____

Is this your first visit to a chiropractor (Yes or No):____If no, when was your last visit____

List the approximate dates of any surgical operations you have had ____

Have you ever suffered any broken bones (Yes or No): Explain: ____

History of antibiotic or cortisone/steroid therapies: ____

Current medications: ____

List any known allergies: ____

List any recent lab work you have had done(e.g. stool, blood, urine, hair analysis)____

What other types of therapy have you tried for this problem(s): homeopathy___herbs__diet modification___vitamin/mineral___massage___

acupuncture____physical therapy____other____

What do you hope to receive from your treatment: symptomatic/pain relief __ correct the cause of my symptoms__ improve my overall

health and well being___ other____

RELEASE OF INFORMATION AND AUTHORIZATION OF THIRD PARTY PAYMENT

I understand that I am responsible for any services incurred on my behalf and agree to pay in full at time of visit unless prior arrangements are made with GOLDEN SUN CHIROPRACTIC WELLNESS CENTER, PLLC. I authorize the release of any information necessary to allow for payment of this claim. I authorize direct payment to the doctor and/or clinic for services billed to my insurance company.

____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

PERMISSION TO TREAT A MINOR

I authorize Dr. Una Forde of Golden Sun Chiropractic Wellness Center, PLLC to administer treatment to:

_________________________________ _________________________________ _______________

NAME OF MINOR SIGNATURE OF PARENT/GUARDIAN DATE

Thank you for choosing Golden Sun Chiropractic Wellness Center, PLLC for your health care needs!