River City Alternative Health

Referred By:_________________________ Rev 09/28/2012

Patient Name:______________________________ Birthdate: _______________ Sex: M / F

Address: ____________________ City: ___________________ State:______ Zip: ________

Telephone: __________________ Cell Phone: ___________________

Occupation:______________ Employer: ________________ Work Phone: ______________

Please provide your EMAIL: ____

We rarely email, but if you prefer not to have any information emailed to you, please leave the email blank. You can always change it later.

Ins. Subscriber Name: ______________________ DOB:______Health Plan:_____________

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

____

____

____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN:_____________________________

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
Can you perform your daily activities? ☐ Yes ☐ No (Explain) _______________________

____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:**_______
WHAT AREAS WERE TAKEN?____

Please check all of the following that apply to you:

Past	Present	**Condition**	Past	Present	**Condition**
☐	☐	Recent serious infection	☐	☐	Prostate Problems _____________
☐	☐	Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS, HEP B or HEP C (circle)	☐	☐	Pregnancy, # of births _______
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Loss ☐ Gain
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	Spinal Pain ☐ Low ☐ Mid ☐ Neck
☐	☐	Stroke (date) _____ Type ________	☐	☐	Arthritis ☐ Osteo ☐ Rheumatoid
☐	☐	Dizziness / Fainting (circle one)	☐	☐	Trauma
☐	☐	Numbness in Groin / Buttocks	☐	☐	Alcohol Use
☐	☐	Urinary Retention	☐	☐	Tobacco Use (Packs/day) _______
☐	☐	Aortic or other aneurysm	☐	☐	Surgeries / Medications: ________
☐	☐	Cancer / Tumor _________________			_____________________________
☐	☐	Osteoporosis / Osteopenia			_____________________________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular / Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ____ **Date:** _______________

106 N. High St., Port Byron, IL 61275 Fax: 888-830-9748

CONTINUED HEALTH HISTORY

PAST	PRESENT		PAST	PRESENT	
☐	☐	Pacemaker / Heart Surgery	☐	☐	Drug Abuse
☐	☐	Heart Attack	☐	☐	Low Blood Pressure
☐	☐	Congenital Heart Defect	☐	☐	Severe / Frequent Headaches
☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease
☐	☐	Heart Murmur	☐	☐	Shingles
☐	☐	Artificial Valves	☐	☐	Tuberculosis
☐	☐	Artificial Bones / Joints	☐	☐	Emphysema / Glaucoma
☐	☐	Kidney Problems	☐	☐	Sinus Problems
☐	☐	Hepatitus	☐	☐	Difficulty Breathing
☐	☐	Psychiatric Difficulties	☐	☐	Asthma
☐	☐	Anemia	☐	☐	Chemotherapy
☐	☐	Rheumatic Fever	☐	☐	Ulcers / Colitis

IN EVENT OF AN EMERGENCY, PLEASE CONTACT:

Person: ____________________________________ Relation: ______________________________

Phone #: _______________________ Alternate Phone #: _________________________

Medical Doctor: ______________________________ Phone #: _________________________

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT PAYMENT:

Name: _____________________________________ Relation: ______________________________

Billing Address: ____
CITY STATE ZIP

Phone #__________________ Work Phone #: ________________

I hereby authorize assignment of my insurance rights and benefits to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. ______
INITIALS

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and / or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____ Date ____/____/____
Signature ☐ Adult Patient ☐ Parent or Guardian