



Rafey Chiropractic
Achieving Your Health Success

PATIENT HISTORY

(PLEASE PRINT)

DATE _____

Name _____ Phone (hm) _____ (wk) _____

Cell _____ Email _____

Address, City, State, Zip _____

Birth Date _____ Age _____ Male Female Spouse's Name (or parent) _____

of Children _____ Married Single Divorced Widowed; Occupation _____

Employed by _____ Work Address _____

City, State, Zip _____ **Social Security #** _____

How were you referred to our office? _____

Have you ever had Chiropractic Care before? _____ If yes, when? _____

List your chief complaints in order of severity:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

List other Doctors consulted for this condition:

1. _____ Address? _____

2. _____ Address? _____

Is this injury or illness work-related? _____ Have you reported it to your employer? _____

Is this injury or illness related to an automobile accident? _____ (If yes, name of YOUR:)

Auto Insurance Co. _____ Policy # _____ Claim # _____ Phone # _____

Address _____ Agent's Name _____

Do you have any type of Health Insurance? _____ Company? _____

Address _____ Policy # _____

Are you covered under any other group or individual health policy through yourself or spouse? _____

If yes, Company's Name _____

Address _____

Spouse's Social Security # _____ Employer _____

Address, City, State, Zip _____

NOTICE: Not all patients require X-rays to determine or verify a diagnosis, type and length of care.

If your examination warrants X-ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for X-rays is for analysis only. The film itself is the property of this office and cannot be released.

I acknowledge that I may have discussed with the doctor a financial situation that may have resulted in a "financial hardship" classification. I further acknowledge that it is my responsibility to notify the doctor if/when this financial situation changes.

Method of Payment you plan to use for today's charges: Check Cash MasterCard VISA

Patient's Signature _____

Are you here for a free scoliosis or spinal exam only? Yes No



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RAFEY CHIROPRACTIC

Welcome

We would like to extend a warm and personal welcome to you. Excellent and quality chiropractic care is our trademark. You will be offered many informative and entertaining educational opportunities while at this office. Lets begin this health process with some basic information. Please read and complete the following forms and return them to the front desk. Thank you for giving us the opportunity to serve you.

We at Rafey Chiropractic are dedicated to the community and are committed to serving the true health care needs of as many people as possible that are within our reach. We acknowledge the devastating effects of the vertebral subluxation on human health and therefore go to extraordinary measures in educating our communities about the benefits of chiropractic for the restoration and maintenance of health. Our mission is to serve as many people as possible with the highest quality chiropractic care. We encourage our patients to help us by participating in this most important mission by spreading the word to your family and friends.

Your attitude about your health is important to us as the specific reason you've consulted our office. Below are four health attitudes.

"Please mark the one that most closely reflects your personal values."

- _____ **PAIN RELIEF.** I only consult a doctor when I have an ache or a pain and discontinue care as soon as it has cleared up.
- _____ **PAIN RELIEF & CORRECTION.** In addition to pain relief, I am interested in correction. I consult specialists occasionally to prevent the problem so it does not reoccur.

"Please check if you are interested in the following:

- _____ **FREE Nutritional Screening.** This is to see if nutrition can help you keep your body healthy.
- _____ **FREE Orthopedic Screening.** This is to see if you would be suited for personal pelvic stabilizers (foot orthotics) to help your spine.

Thank you, we look forward to a healthy relationship with you!

Dr. Carl Rafey and Staff

Patient's Name: _____ Date: _____





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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE:

Patient: _____

Employer: _____

Claim/Group #: _____

SSN/ID #: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

P. Carl Rafey, DC
2450 Kipling Ave., Suite 109
Cincinnati, OH 45239

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O

the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____, 20____.

_____ Signature of Policyholder	_____ Witness
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Signature of Claimant, if other than Policyholder