



Knewtonson  
Health Group

New Patient  
6 Years - Adult

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone Numbers (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Is it O.K. to contact you at work?  Yes  No Work # \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Marital Status  Single  Married  Separated  Divorced  Widowed  
Spouses Name \_\_\_\_\_ Phone Number(s) \_\_\_\_\_  
Children's Names and ages \_\_\_\_\_  
\_\_\_\_\_  
Emergency contact name \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone Number(s) \_\_\_\_\_  
Favorite hobbies and interests \_\_\_\_\_

### Financial Responsibility

Who is responsible for payment? \_\_\_\_\_  
How will you pay for your care? \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group Policy # \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_  
Relation \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_

### What Brings you here?

Have you ever had chiropractic care?  Yes  No  
If yes, please tell us the doctor's name. \_\_\_\_\_  
Were you pleased with your care?  Yes  No  
How did you find out about our office? \_\_\_\_\_  
Is this appointment related to:  Work  Sports  Auto  Personal Injury  Other  
\_\_\_\_\_

When did the accident occur? \_\_\_\_\_  
Attorney (if applicable) \_\_\_\_\_ Phone Number(s) \_\_\_\_\_  
Are you receiving care from other health professionals?  Yes  No  
If yes, please name them and their specialty. \_\_\_\_\_

Please list any drugs or medications you are taking. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any vitamins/herbs/homeopathics/others you are taking. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant?  Yes  No If yes, what month? \_\_\_\_\_

Current Health

What are your most pressing health concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For how long? \_\_\_\_\_

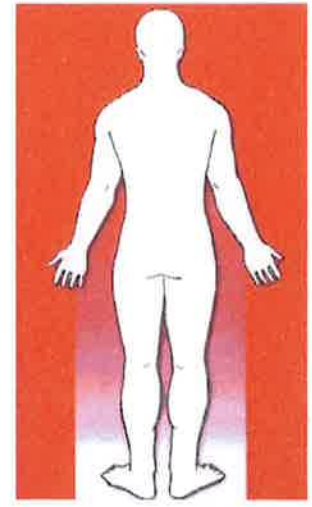
Is it:  Getting Worse  Improving  Intermittent  Constant  Can't Say

Where is the problem? Please use the illustrations and lines below to explain.



**Front** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Back** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Do you have:  Pain  Numbness  Tingling  Aches

Is your pain:  Sharp  Dull  Throbbing  Constant  Intermittent

Are your symptoms affected by:  Sitting  Standing  Walking  
 Bending  Lying Down  Weather

Please explain. \_\_\_\_\_

Do you feel:  Cramps  Burning  Other  
 Swelling  Stiffness \_\_\_\_\_

Do your symptoms Interfere with:  Work  Sleep  Other  
 Day-to-Day Activities  Play \_\_\_\_\_

Please explain. \_\_\_\_\_

On a scale of 1 – 10 (1 least, 10 most), please rate the severity of your symptoms:

1      2      3      4      5      6      7      8      9      10

### Health History

Do you have or have you had, any of the following: *(Please check all that apply)*

Pneumonia       Mumps       Influenza       Rheumatic Fever       Stroke  
 Pleurisy       Polio       Chickenpox       Thyroid Disease       Diabetes  
 Epilepsy       Cancer       Depression       Whooping Cough       Anemia  
 Rashes       Measles       Arthritis       Heart disease       Other

If you have been diagnosed with another disease or condition, please describe.

Does any member of your family have/had any of the above conditions? If yes, list here.

Do you use:  Coffee  Tea  Artificial Sweeteners  Sugar  
 Alcohol  Cigarettes  Recreational Drugs

Have you ever suffered from: *(Please check all that apply)*

Neck Pain       Difficulty Breathing       Excessive Urination  
 Low Back Pain       Stuffy Nose       Discolored Urine  
 Headaches       Allergies       Gas/Bloating After Meals  
 Migraines       Fainting       Heartburn  
 Arm Tingling       Weight Loss       Colitis  
 Back Tingling       Poor Appetite       Irritable Bowels  
 Shoulder Pain       Excessive Appetite       Black or Bloody Stools  
 Hand Pain/Tingling       Nervousness       Constipation





TO OUR PATIENTS: Please read and sign the form below. Ask questions if there is something you do not understand.

Please check to indicate approval:

**RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:**  
 -to health care providers directly involved in my care.  
 -to State, Federal and accrediting bodies for required reporting data and/or surveys for compliance.  
 -for purposes of my care and for business operations.  
**Note: Records are not automatically sent to your physician. They must be requested.**

**ASSIGNMENT OF BENEFITS/BILL MY INSURANCE:**  
 -I authorize Knewton Health Group to send my bills for my medical care and treatment to my insurance company and/or Medicare or Medicaid for payment, to the extent my insurance company and/or Medicare or Medicaid id required to pay the bill under terms of my insurance policy or by law.  
 -I request that my insurance company and/or Medicare or Medicaid pay Knewton Health Group and the providers who are involved in my treatment.  
 -I consent to the release of my medical records by Knewton Health Group to my insurance company and/or Medicare or Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.  
 -I agree to pay for charges not covered by my insurance.  
**-I understand that if I do not check this box Knewton Health Group will send a bill directly to me for payment.**

**RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH:**  
 -I agree that my records may be used by Knewton Health Group for medical or scientific study.  
 -No information which can identify me as a patient or participant in any such study will be shared.  
 -I may revoke this in writing at any time.

By signing this form, I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose of treatment, and that I have the right to refuse recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where Knewton Health Group has already made disclosures in reliance to the consent.

I consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time due to the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

If applicable, patient's relationship to guardian: \_\_\_\_\_

Check only if applicable (one-time acknowledgment)

I acknowledge that I have been offered a copy of Knewton Health Group's Privacy Practices Information. If I would like a copy in the future, I will ask for one.



Knewton  
Health Group

## Credit Policy And Patient Responsibility

Thank you for choosing Knewton Health Group as your health care provider. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our Credit and Financial Policies below. Please read carefully and sign below to begin treatment.

All patients complete our information and insurance forms.

### **Co pays are due at time of service.**

For your convenience, we accept cash, check and all major credit cards, including Visa, Master Card, Discover and American Express.

We offer physical therapy and chiropractic cash plans. Payment is due at time of service.

We offer payment plans with prior credit approval and signed agreements.

### **Patients with insurance coverage**

We may accept assignment of insurance benefits at first visit. However, we do require your co-payment be paid at the time of the service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event that your insurance denies any claim.

### **Usual and customary rates**

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for all usual and customary charges, regardless of what your insurance company's arbitrary discrimination of usual and customary rates.

### **Delinquency**

In event your account becomes past due and is referred to an outside collection agency or attorney you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

**I have read and understand Knewton Health Group Credit and financial policy with the respect to payment on my account.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**23505 Smithtown Road, Suite 100, Excelsior, MN 55331 952-470-8555**