



Lakeside Sports

Chiropractic Center
& Motorsports Rehab

Dr. Jennifer Lidstrom & Dr. Jared Scholtisek
19924 Jetton Rd. Suite 101 Cornelius, NC 28031
Phone 704.896.8446

www.LakesideSportsChiro.com

Dear Patient:

Please complete this questionnaire. Your answers will help to determine if we can help you. If we sincerely believe that we can treat your condition satisfactorily, we will gladly accept you as a patient. Thank you.

Today's Date: _____

1. Full Name: _____ SS# _____

2. Age: _____ Date of Birth: _____ Gender: M F Marital Status: _____

3. Address: _____ City: _____ State: _____ Zip Code: _____

4. Cell Phone: _____ Home Phone: _____

5. E-mail Address: _____

6. Employer: _____ Company Phone # _____

7. Occupation: _____ For how long? _____

8. Contact in case of emergency: _____ Phone # _____

9. Primary Care Doctor Name: _____ Phone # _____

10. How did you hear about us? _____

INSURANCE INFORMATION

Insurance Company: _____ Policy # _____

Policy Holder Name: _____ DOB: _____

Policy Holder's Employer: _____

10. Are your symptoms the result of an accident? YES NO
11. Date of the Accident _____ Type of Accident: Auto Workers Comp. Other
12. How long have you had these symptoms? _____
13. Have you ever had these symptoms before? NO YES When? _____
14. Are your symptoms getting worse? YES NO Constant Comes and Goes
 IF NOT INVOLVED IN AUTO OR WORKERS COMP. ACCIDENT, SKIP TO QUESTION # 26
15. If an Auto Accident, were you: DRIVER FRONT PASSENGER REAR PASSENGER
16. Were you wearing a seat belt and shoulder harness? YES NO
17. Did you lose consciousness? NO YES For how long? _____
18. Were you SURPRISED or AWARE when the accident occurred?
19. Your vehicle was STOPPED or MOVING at time of impact?
20. Were you looking FORWARD DOWN LEFT or RIGHT?
21. Did any part of your body hit the inside of the car? _____
22. Did you have immediate pain after the accident? _____
23. If a Work Accident, what happened? _____

24. Have you been to a hospital? YES NO By ambulance? YES NO
25. Which hospital did you go to? _____ When did you go? _____
26. Have you had X-Rays? YES NO What part of the body? _____
27. What makes the pain better? ICE HEAT PAIN KILLERS SITTING LYING DOWN
28. What Medications are you currently taking? _____

29. Do you or your family have any medical problems? YES NO
 Please explain. _____
30. Do you smoke? YES NO How much? _____
31. Do you drink? YES NO How much? _____

7. Do you have ankle pain? YES NO

NECK SYMPTOMS

1. Do you have neck pain? YES NO

2. There is pain in: LEFT ARM RIGHT ARM LEFT SHOULDER RIGHT SHOULDER

3. Do you feel numbness in your arms? YES NO

4. Do you have difficulty turning your head? YES NO

5. Do you have headaches? YES NO

6. Is there pressure behind your eyes? YES NO

7. Do you experience nausea? YES NO

8. Do you have difficulty swallowing? YES NO

9. Do you have chest pain? YES NO

10. Has your nervousness increased? YES NO

11. Does the neck pain affect your vision, hearing or balance? YES NO

12. TYPES OF PAIN (Circle one): Stabbing, Throbbing, Sharp, Dull, Cramping, Grabbing

DISABILITY

1. How many days or weeks have you lost from work? _____

2. What physical restrictions do you have? _____

Lakeside Sports Chiropractic Center & Motorsports Rehab

By signing below I _____

(PRINT NAME)

elect to assign insurance benefits payments to Lakeside Sports Chiropractic Center for all treatments rendered within their facility.

Patient Signature _____ **Date** _____



Lakeside Sports
Chiropractic Center
& Motorsports Rehab

**LAKESIDE SPORTS CHIROPRACTIC CENTER
& MOTORSPORTS REHAB**

MEDICAL RECORDS RELEASE

DATE: _____

TO: _____
DOCTOR OR HOSPITAL

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE

TO: Lakeside Sports Chiropractic Center Phone: (704)896-8446
19924 Jetton Rd, Suite 101 Fax: (704) 896-8495
Cornelius, NC 28031

The complete medical **x-rays reports** and **emergency records** related to my _____
which occurred on or about _____.

PRINTED NAME _____

SIGNED _____ SS# _____ DOB _____

LAKESIDE SPORTS CHIROPRACTIC CENTER & MOTORSPORTS REHAB

PAYMENT POLICY

Thank you for choosing Lakeside Sports Chiropractic Center as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your Chiropractic benefits.
2. **CO-PAYMENTS AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE.** All patients must complete our patient information from before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **COVERAGE CHANGES.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. **MISSED APPOINTMENT.** Our policy is to charge \$25.00 for missed appointments not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.
7. **RETURNED CHECKS.** Our policy is to charge \$25 for every returned check. After two (2) returned checks we will accept cash or a credit card for services rendered.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date