



Lakeside Sports
Chiropractic Center
& Motorsports Rehab

Dr. Jennifer Lidstrom & Dr. Laura Watterson

19924 Jetton Rd. Suite 101 Cornelius, NC 28031

704-896-8446

Today's Date

 / /

Signature of Patient _____

Signature of Parent/Guardian _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ **Nick Name** _____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home Email _____ **Work Email** _____

Which email address would you like us to use to communicate with you? (Check one) Home Work

Contact Method (Check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth / / **Age** _____ **Gender** (Check one) Male Female Unspecified

Marital Status (Check one) Single Married Other **SSN** _____

Employment Status (Check one)

Employed FT Student PT Student Other Retired Self Employed

Race (Check one)

- | | | | |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I choose not to specify |

Multi-Racial (Check one) Yes No Unknown

Ethnicity (Check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (Check one)

- | | | | | | |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Armenian | <input type="checkbox"/> I choose not to specify | |

Continued ...

Patient Name _____ Number _____ Date _____

Verification Question (Choose only one question by checking the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
- What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
- What was the make of your first car? When is your anniversary? What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10
- No interest* *Very Interested*

Current medications, including dosage if known.

If there are no current medications, check here:

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
- 2) _____ 4) _____

Occupation _____ **Employer** _____

Who referred you to us? _____ **How else did you hear about us?** _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine **Other** _____

Continued ...

Patient Name _____ Number _____ Date _____

Other doctors or therapists who have treated **THIS** condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

Do you have a family physician? Name: _____ Phone Number: _____

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure
If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your **low back** or **neck/spine** in the past 28 days? Yes No

<p>To be performed by clinic staff:</p> <p>Height: _____ inches Weight: _____ pounds BP: _____ / _____</p>

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