

The Mladenoff Clinic

Patient Billing Information

I understand that all payments are due to **The Mladenoff Clinic** at the time services are rendered. All bills are due and payable in full.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations.

Initial Consultation: No charge. (Initial consultation does not include any exams, x-rays or lab tests are subject to separate outside fees. All fees are subject to change without notice.

A charge of \$25.00 will be assessed for a missed appointment. We require a 24-hour notice for cancellations.

If your insurance company requests copies of your medical records, a charge of \$10.00 for copy charge as well as 10 cents per page will be billed to you. You may try to recover this charge from your insurance company.

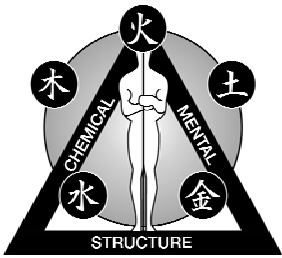
If you would like the Mladenoff Clinic to mail your receipt to your insurance company, please provide our staff with a copy of your insurance card.

I have read and understand how the payments are due and I agree to these policies and procedures.

Signature

Date

* This document will act as a lien against auto insurance in an automobile accident.



THE MLADENOFF CLINIC

NEW PATIENT INFORMATION

Client # _____ Today's Date: _____

PLEASE PRINT CLEARLY

Full Name: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home pH: (____) _____ Work Phone: (____) _____ Cell pH (____) _____

Gender M / F Soc Security # _____ Birth Date: _____ Age: _____

Marital Status S / M / D / W # of Children _____ # of Siblings _____ # of Older _____ # of Younger _____

Work Status: Full Time Part Time Retired Not Employed

Females: Last Menstrual Period: _____ Pregnant Y / N Nursing Y / N

Employer: _____ Occupation: _____

In case of Emergency contact: _____ Relationship: _____

Emergency contact phone # (____) _____ Name of Spouse/Parent/Guardian _____

How did you hear about the Mladenoff Clinic? Whom may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1. The patient understands and agrees to allow the Mladenoff Clinic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written permission.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Mladenoff Clinic to assure that your records are not readily available to those who do not need them.
6. If a patient has a complaint about the privacy of records please see our office manager or Dr. Mladenoff.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Date

HEALTH CONCERNS: Please list your top health concerns in order of priority.

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

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
 I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
 I am looking to take care of my problems and then go on to "achieve optimal health and wellness".

COMPLAINT/PROBLEM: In relation to your primary condition:

When did you first seek treatment for this problem? _____

Has another doctor(s) treated you for this condition Y N If yes whom? _____ Treatment(s): _____

Have you had any intolerance or reactions to treatments? Y N Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? Y N Same Better Gradually Worse

How frequent is this condition? Constant daily Intermittent Night Only

How long does it last? All Day A few Hours Minutes

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

How long has it been since you really felt good? Days Weeks Months Years > 10 years

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other _____

What makes the problem worse?: Standing Sitting Lying Bending Lifting Testing Other _____

Is there anything you can do to relieve the problem? Y N Describer: _____

If no, what have you tried that has not helped? _____

What do you believe is wrong with you? _____

Are there any other conditions/symptoms related to your major symptom? Y N If yes, what? _____

Have you been in an auto accident? Never Past year Past 5 years Over 5 years

Describe: _____

Please check all of the symptoms that apply: (P=Past / C = Current)

P / C

- Headache
- Facial Pain
- Eye Pain
- Blurred Vision
- Dizziness
- Earache
- Forgetfulness
- Confusion
- Sinusitis
- Teeth Grinding
- Dry Mouth
- Excessive Thirst
- Unpleasant Taste
- Neck Pain
- Sore Throat
- Lump in Throat
- Swallowing Pain
- Unsteady Voice
- Shoulder Pain
- Persistent Cough
- Chest Pressure
- Slow Heart Rate
- Rapid Heart Rate

P / C

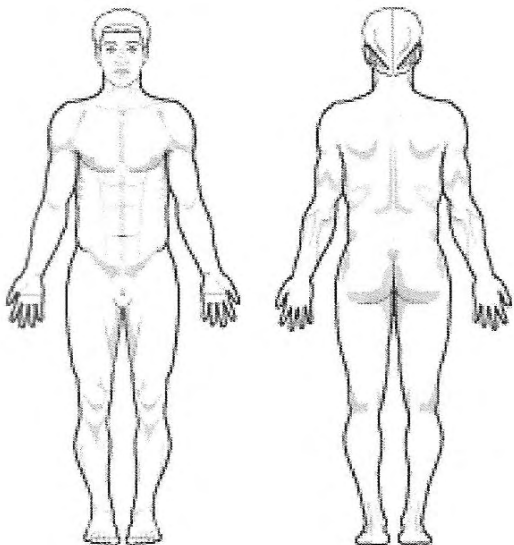
- High Blood Pressure
- Low Blood Pressure
- Abdominal Pains
- Nausea/Vomiting
- Poor Appetite
- Fullness of Bladder
- Urinary Difficulty
- Frequent Urination
- Constipation
- Hemorrhoids
- Decreased Sex Drive
- Menstrual Irregularities
- Elbow / Hand pain
- Tingling in Hands
- Clammy Hands
- Low Back Pain
- Hip Pain
- Knee Pain
- Poor Circulation
- Swollen Joints
- Joint Stiffness
- Swollen Ankles
- Ankle / Foot Pain

P / C

- Tingling in feet
- Walking problems
- Sore muscles
- Weak muscles
- Paralysis
- Shakiness
- Sweating
- Insomnia
- Fainting
- Convulsions
- Irritability
- Impatience
- Fatigue
- Feel loss of control
- Other _____

List and describe the problems you are having and draw them on the chart below.

1. _____
2. _____
3. _____
4. _____
5. _____



GRADE YOUR PAIN	
1 (= none) to 10 (= very severe)	
PROBLEM #	GRADE
1	1 2 3 4 5 6 7 8 9 10
2	1 2 3 4 5 6 7 8 9 10
3	1 2 3 4 5 6 7 8 9 10
4	1 2 3 4 5 6 7 8 9 10
5	1 2 3 4 5 6 7 8 9 10

ALLERGIES: Please check and list all allergies.

Food: _____
 Seasonal: _____
 Environmental: _____
 Medications: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Drug Name	Date Started
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Arthritis Drugs		
<input type="checkbox"/> Behavioral Modification Drugs		
<input type="checkbox"/> Blood Pressure Lowering Drugs		
<input type="checkbox"/> Cholesterol Lowering Drugs		
<input type="checkbox"/> Hormone Replacements (HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> Other		

Scars/Surgical Procedures: List all scars and surgeries _____

Supplements: Do you take Vitamins/Supplements Herbs/Homeopathics? If yes, who recommended them?

HABITS:	Heavy	Moderate	Light	None		5-7x/wk	3-5x/wk	1-3x/wk	Type	Time
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		8+ Hrs	7-8 Hrs	6-7 Hrs	5-6 Hrs	<5 Hrs
Soda Pop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5+	4	3	2	1
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		64+ oz	32-64oz	16-32oz	< 8 oz	
					Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

WORK ACTIVITY: Heavy Labor Light labor Mostly Sitting Mostly Standing Walking/Moving Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
 (G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcoholism/Drug Abuse | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage(s) | <input type="checkbox"/> Tumor(s) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Vaccine reaction |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Goitre | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Detached Retina | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures/Fainting | |
| <input type="checkbox"/> Diverticulitis / IBS | <input type="checkbox"/> HIV / ADIS | <input type="checkbox"/> Stroke | |

 Patient's Name (Printed)

 Patient Signature

 Date: