BRIDGEWATER CHIROPRACTIC

DR. ROLANDO BELLO, DC
724-371-0280

CONFIDENTIAL PATIENT INFORMATION

We welcome you to Bridgewater Chiropractic! The information below is confidential and meant for us to support your healthcare needs. In order for us to fully understand your healthcare needs, please complete this form neatly, accurately and completely. Thank you.

Date_____ SS#_____

Name_____ Cell Phone_____
Home Phone_____
Office Phone_____

Please note, your will receive a text message reminder one (1) day prior to any future appointments. Your response is required as we strive to leave emergency visits open daily.

Address (Street)_____
City_____ State _____ Zip_____
Age_____ Date of Birth_____ Marital Status: S M W D Number of Children_____
Occupation_____

Employer_____
Address _____
Other Nearest Relative_____ Phone_____

Personal Email_____

How did you hear about us / Who can we thank for referring you?
_____

LIST PRESENT COMPLAINTS, INJURIES, DATE OF INJURY AND DURATION

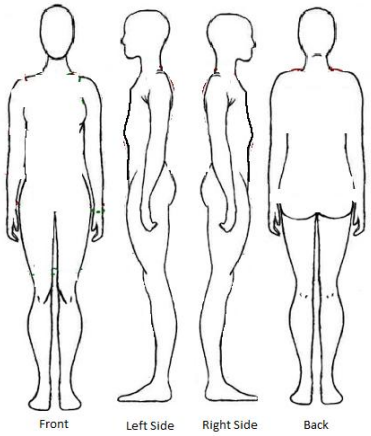
1.

2.

3.

4.

5.



WHAT SURGERIES HAVE YOU HAD?
Type/When/Doctor/Results_____
_____
_____
_____

LIST FORMER SERIOUS ACCIDENTS AND FALLS: (AUTO, WORK, HOME, LEISURE, SPORTS, OTHER)
What/When/Symptoms/Treatment/Results_____
_____
_____
_____

LIST BROKEN BONES: When/How/Doctor/Results
_____
_____
_____
_____

LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU TAKE: What / Frequency / Doctors / Side Effects
_____
_____
_____
_____
_____

LIST ANY DISEASE OR ILLNESS WITH WHICH YOU HAVE BEEN DIAGNOSED: (Examples: Diabetes, Heart Disease, High Blood Pressure, Stroke, Asthma, Ulcers, Cancer, Arthritis, Depression)
_____
_____
_____
_____

WORK/LEISURE ACTIVITIES Work Responsibilities-lifting, bending, stooping, twisting, turning, carrying, walking, standing, etc Leisure- sports and exercise type, frequency, length of time, etc.
_____
_____
_____
_____

CANCELLATION, NO SHOW POLICY & FINANCIAL RESPONSIBILITY

IMPORTANT: You MUST respond to text message reminders regarding your appointment(s) which are automatically sent 24 hours prior to your appointment.

We understand that situations arise in which you must need to reschedule your appointment. It is therefore requested that if you must cancel your appointment you provide, at minimum, 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment time.

This is of extreme importance as Bridgewater Chiropractic strives to have "emergency" appointments available for those that need same-day visits. Without your response to text/voicemail reminders OR no-show appointments, we cannot effectively serve our patients as a whole.

Patients who do not show up for their appointment without notification to our office staff will be considered a NO SHOW. Patients who No-Show two (2) or more times within a 6 month period may be dismissed from the practice. **Patients will be subject to a $25 fee for office appointment No Shows without notification to the office staff.** Cancellation or No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We also understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Financial Responsibility for Care: If your insurance does not reimburse for the services listed below, you may be financially responsible for such differences. Although some insurance cards claim to cover certain adjustment(s), examination(s), etc. your policy may not cover such procedures that Dr. Bello determines you may need.

As such, your insurance may not reimburse for the following:

- Physical Examination 99204
- Extremity (Extraspinal) Adjustment 98943

Please sign that you have read and understand the statements above.

X _____ _____

Patient Name **Date**

X _____

Patient Signature

X _____

Relationship to Patient if under the age of 18

DOCTORS COMMENTS

Informed Consent For Chiropractic Care: Prior to receiving chiropractic care, a health history and physical examination will be completed upon your first visit. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed; i.e. x-rays, etc. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a course of action prior to beginning care.

Please alert Dr. Bello and/or the office staff should anything change between your first visit and present time; i.e. surgeries performed, new medications prescribed, etc.

Chiropractic care, like all forms of health care, while offering considerable benefit may also have some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

I understand the statements above and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

X _____ _____

Patient Name **Date**

X _____

Patient Signature

X _____

Relationship to Patient if under the age of 18