STANO CHIROPRACTIC, LLC
58147 Columbia River Hwy, Suite B
St Helens, OR 97051
Phone: 503-438-4733
Fax: 503-410-5351

Patient Intake Form **Todays Date:_____**

Name _____ Phone ( ) _____

Address _____ City _____ State _____

Zipcode _____ Age _____ Birthdate _____/_____/_____ Gender: M / F

Email_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Student

Occupation _____ Employer _____

Emergency Contact _____ Phone (___)_____ Relationship _____

Please describe your current problem

_____

How did your problem begin

_____

Date Problem began _____ Other doctors seen for this _____

List other treatments or tests you've had for this condition

_____

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your current pain/symptoms: ☐ Sharp/Stabbing ☐ Burning ☐ Throbbing ☐ Shooting ☐ Tingling ☐Gripping
☐ Dull ☐ Numbness ☐Soreness ☐Aches ☐ Weakness ☐ Other _____

Since it began, is your problem: ☐ Improving ☐ Getting Worse ☐ No Change

What makes the problem better? ☐ Nothing ☐ Lying Down ☐ Standing ☐ Walking ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Other _____

What makes the problem worse? ☐ Nothing ☐ Lying Down ☐ Standing ☐ Walking ☐ Sitting ☐ Movement
☐ Exercise ☐ Inactivity/Rest ☐ Other _____

STANO CHIROPRACTIC, LLC
58147 Columbia River Hwy, Suite B
St Helens, OR 97051
Phone: 503-438-4733
Fax: 503-410-5351

Patient Health Questionnaire

Patient Name _____ DOB:_____

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- ☐ Angina
- ☐ Anorexia
- ☐ Aortic Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Infection
- ☐ Blood Disorder
- ☐ Breast Lump
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Chronic Sinusitis
- ☐ Colitis
- ☐ Convulsions
- ☐ Diabetes
- ☐ Depression
- ☐ Digestive Disorders
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headache
- ☐ Heart Disease
- ☐ Heartburn/Indigestion
- ☐ Hepatitis
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Liver/Gallbladder Problems
- ☐ Kidney Disorders
- ☐ Loss of Bladder Control
- ☐ Nervousness
- ☐ Pacemaker
- ☐ Pain - Neck
- ☐ Pain - Mid Back
- ☐ Pain - Low Back
- ☐ Pain - Arm/Elbow
- ☐ Pain - Hand
- ☐ Pain - Wrist
- ☐ Pain - Shoulder
- ☐ Pain - Ankle or Foot
- ☐ Pain - Leg
- ☐ Pain - Knee
- ☐ PMS
- ☐ Prostate Problems
- ☐ Rapid Heartbeat
- ☐ Rheumatic Fever
- ☐ Pregnancies
- ☐ Scoliosis
- ☐ Stroke
- ☐ Swelling, Stiffness of Joints
- ☐ Tinnitus (Ear Noises)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Vision Disturbances
- ☐ Venereal Disease
- ☐ Other _____

Height: _____ feet _____ inches

Weight: _____ pounds

For all patients over 13 yrs. old:

- ☐ Smoking - Packs/Day_____
- ☐ Alcohol - Drinks/Week _____
- ☐ Coffee/Caffeine Drinks - Cups/Day _____
- ☐ Alcohol Dependence
- ☐ Drug Dependence

Please list all allergies including allergies to medications _____

_____

List all medications you are presently taking (including vitamins & supplements)

_____

List any surgeries, fractures, serious illnesses or hospitalizations _____

_____

Pediatric Records: (under 17) Are your immunizations up to date? ☐ Yes ☐ No

Family Health History:

If a family member has had any of the following, please mark the appropriate box and list whom the family member is:

☐ Cancer ☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure ☐ Chronic Headaches
☐ Epilepsy ☐ Lupus ☐ Lung Problems ☐ Chronic Back Problems ☐ Rheumatoid Arthritis
☐ Alcoholism Other _____

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

STANO CHIROPRACTIC, LLC
58147 Columbia River Hwy, Suite B
St Helens, OR 97051
Phone: 503-438-4733
Fax: 503-410-5351

Patient Insurance Information

Patient Name _____ DOB:_____

INSURANCE ASSIGNMENT, RELEASE OF INFORMATION, AND AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Stano all insurance benefits, if any, otherwise payable to me for the services rendered. If enrolled with an HMO and without the appropriate referral or authorization from my Primary Care Physician, I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Dr. Stano to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of benefits and to authorize the use of this signature on all insurance submissions.
A copy of this document shall be considered as valid as the original.

Patient or Guardian Signature _____ Date _____

PATIENT COMMUNICATION AUTHORIZATION

Dr. Stano and members of her staff may need to contact you with appointment reminders, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with the person who answers the phone. This contact could also be made through email.

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please know that we are very concerned with protecting the privacy of your personal health information. While the law requires us to notify you about this disclosure, please understand that we have, and always will, respect the privacy of your health information. However, please be advised that it may be necessary for us to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. I have read the above privacy pledge and agree to its terms.

Date: _____Name of Patient (print)_____

Signature of Patient/Personal Representative _____

STANO CHIROPRACTIC, LLC
58147 Columbia River Hwy, Suite B
St Helens, OR 97051
Phone: 503-438-4733
Fax: 503-410-5351

STANO CHIROPRACTIC CLINIC FINANCIAL POLICY

1) We accept cash, check, Visa, MasterCard, and Discover
2) All payments are due at the time of service, unless special arrangements have been agreed upon prior to visit.
3) All co-pays will be due at the time of service, once your insurance coverage has been verified and we have established what your responsibility is.
4) As a courtesy to our patients, we will bill your insurance company for you. Please keep in mind that if there is a discrepancy, we will let you know as soon as possible; however, we will not get involved with any dispute between you and your insurance carrier.
5) If you have a credit balance, we will reimburse you after payment has been received.
6) All supplements/vitamins, lab work, supports and other supplies **must** be paid for at the time they are received.
7) You are responsible for timely payment of you account.

Workers Compensation Claims

8) All workers compensation cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out and a claim is filed. If the claim is denied, we will bill your private insurance carrier, if you have coverage. Please keep in mind that if your claim is denied, then you are responsible for prompt payment of your account.

Personal Injury/Motor Vehicle Accidents

9) Personal injury and auto accident cases will be billed to your auto insurance company, providing that a claim has been filed and the appropriate paper work has been done.
10) Keep in mind we do not do third party billings to other insurance companies.
11) If you choose not to file a claim with your auto insurance company, or are uninsured, your account will be treated as a cash account, and all fees will be due at the time of service.
12) Generally supplements/vitamins, lab work, supports and other supplies may not be covered by insurance companies, and must be paid for at the time they are received. Should the insurance company pay, we will reimburse you for the amount paid.

I have read, understand and agree with the above financial policy.

_____ _____