

Hamel Chiropractic and Wellness -PATIENT INFORMATION

(Please fill in your information **in detail** so we can make our BEST recommendations for your treatment)

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Best Email Contact: _____ Cell# _____

Sex: ___M ___F Height: _____ Weight: _____ Age: _____ Date of birth: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name: _____ # of Children: _____

Name of Primary Care Doctor/MD _____

How did you find out about our office? _____

Where is your pain and/or other symptoms? (check what applies)

Neck and back Pain/Stiffness Sciatica Knee Pain Bulging/Herniated Discs/Degeneration
 Headaches/Migraines Hip Pain Arthritis/Joint Inflammation Shoulder Pain Carpal Tunnel

How long have you been dealing with these aches/pains? 1 week, 1 month, 1 year, over 1 year

What have you tried in the past to improve your condition?(Circle): Medicine, PT, Chiro, Massage, Exercises, Cryotherapy, Surgery, Supplements. Did anything help? _____

What are your goals for seeking out treatment for your chief complaint(s)?

I just want to take pills to feel better

I would like to correct the underlying problem so it doesn't return

I want to correct the underlying cause and have a strategy to be pain free long term.

What other health issues do you have that might be contributing to your aches and pains? (Circle)
Overweight, Poor Diet, Diabetes, Arthritis, Autoimmune Condition, Stress, Anxiety, Poor Sleep, Fatigue

What are you not able to do or having lots of difficulty doing because of the pain?(work, sleep, exercise)

Would you like to learn corrective exercises to help you feel better quicker and have the treatments be more effective? Yes ___ No ___

Are you open minded to taking natural supplements to help with pain, inflammation and to help speed up the healing process? Yes ___ No ___

Is there any other health concerns that you would like Dr. Hamel to address: _____

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Dr. Tyler Hamel, DC for medical services, treatments or medical supplies furnished to me by Dr. Tyler Hamel DC.
2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.
4. Dr. Tyler Hamel, DC to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and treatments provided.
5. Dr. Tyler Hamel, DC to contact me by telephone or mail regarding my medical treatments, or a medical supplies order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # () _____

SIGN YOUR NAME HERE → [] → **TODAY'S DATE** → [/ /]

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Dr. Tyler Hamel DC and/or any of our corporate affiliates for any medical services or supplies furnished to me by Dr. Tyler Hamel DC. I authorize any holder of medical information about me to release to Dr. Tyler Hamel DC, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

I _____ appoint _____ to act as
(name of beneficiary) (name of representative)
my personal representative with Medicare, Medicaid or private insurance.

Their relationship to me is spouse, child, parent, sibling, other _____.
(choose one) (or write in)

The reason I cannot sign is: _____.
(list reason)

My representative does or does not live with me.
(choose one)

If not, their address and phone number is:

Address: _____ Phone: _____

City/St/Zip: _____

Signature: _____ Date: _____

My signature and date above authorizes the above named person to sign on my behalf.