Old Mill Chiropractic
Samuel E. Durbin, D.C.

235 Jungermann Rd., Suite 209, St. Peters, MO 63376
Phone: (636) 928-7387 Fax (636) 928-1269

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's Date: ______________

Name: ______________________________ Date of Birth: ______________

Address: ______________________ City: ______________ State: ____ Zip: ______

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Email: ______________________

Social Security #: ______________________ Age: ________ ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other ______________

Number of children: __________ Ages of children: _____, _____, _____, _____, _____, _____

Emergency Contact Name: ______________________________ Phone: ______________

Your Occupation ______________________ Your Employer: ______________________

Referred to this Office by: ______________________________

Payment for Services will be by: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance ☐ Automobile Insurance ☐ Worker's Compensation

Name of Insurance Co.: ______________________ Insured's Name: ______________

Insured's Social Security #: ______________________ Insured's Date of Birth: ______________

Are you covered by more than one insurance company? ☐ Yes ☐ No Name ______________

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

Please indicate which conditions have been experienced by marking appropriate boxes.

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition ______________________________ Date of Last Physical Exam: ______________

Habits: Nicotine/Tobacco usage per day: ______ Alcohol/Drinks per week: _____ Coffee/Cups per day: ______

Vitamins/Herbs (list all being taken): ______________________________

Exercise: _____ None _____ Moderate ____ Daily

SURGICAL HISTORY:

1. ______________________________ Date: ______________
2. ______________________________ Date: ______________
3. ______________________________ Date: ______________

Have you ever had a metal implant? ☐ Yes ☐ No Have you ever been to a chiropractor ? ☐ Yes ☐ No

ACCIDENT HISTORY: ☐ Job ☐ Auto ☐ Other 1. ______________________ Date: ______________
☐ Job ☐ Auto ☐ Other 2. ______________________ Date: ______________
☐ Job ☐ Auto ☐ Other 3. ______________________ Date: ______________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

List your complaint, rate your pain with a number, and indicate type of pain:

1.__________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

Type of Pain: ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing ❑ None

2.__________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

Type of Pain: ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing ❑ None

3.__________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

Type of Pain: ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing ❑ None

4.__________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

Type of Pain: ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing ❑ None

5.__________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

Type of Pain: ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing ❑ None

6.__________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain: ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

Type of Pain: ❑ Aching ❑ Burning ❑ Dull ❑ Pulling ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Stinging ❑ Throbbing ❑ None

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT
WHEN AND HOW OCCURRED? ____

____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT
❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: ____________________
SYMPTOMS HAVE PERSISTED FOR: ____HOUR(S) ____DAY(S) ___WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN? __________________________

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑YES WHAT KIND? ____________________
ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES WHAT KIND? ________________________
ARE YOU PREGNANT? ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD____________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

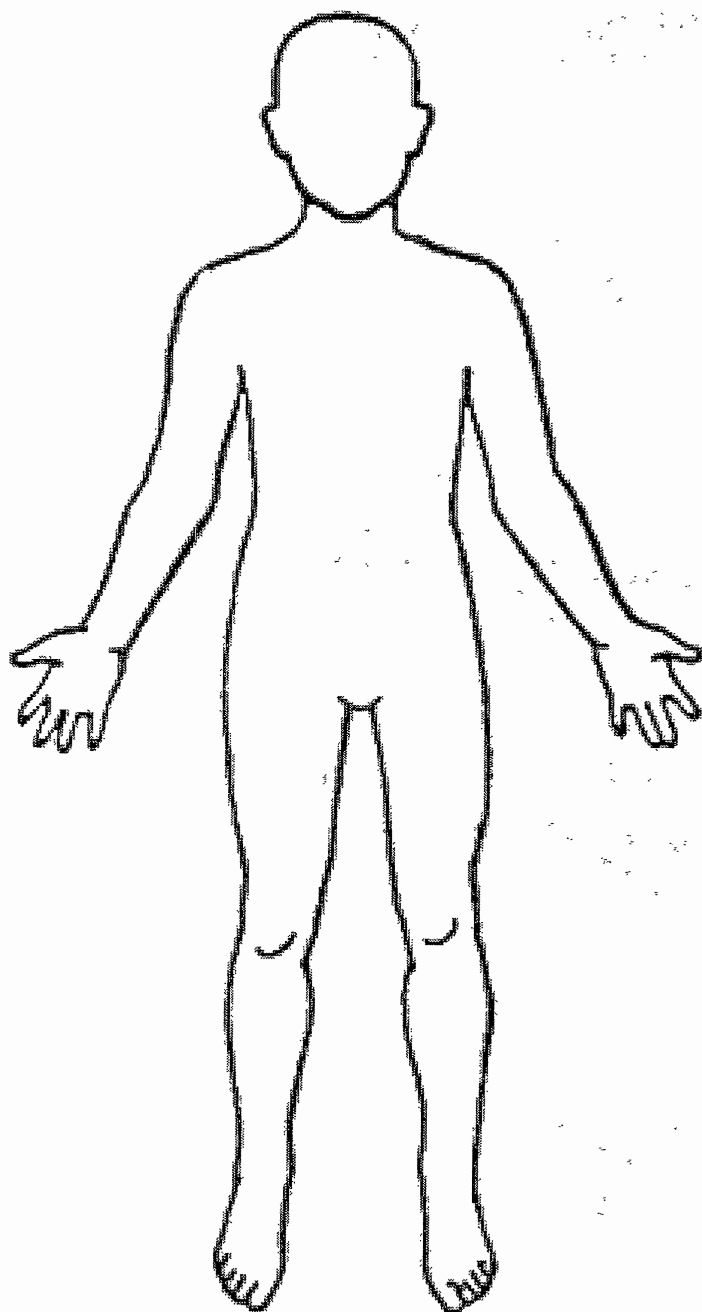
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Patient Name: ______________________________ Appointment Date: ______________

These are front and back views of the human body. Please use a highlighter or marker and color anywhere you are experiencing pain, tingling, numbness, or having ANY problems.

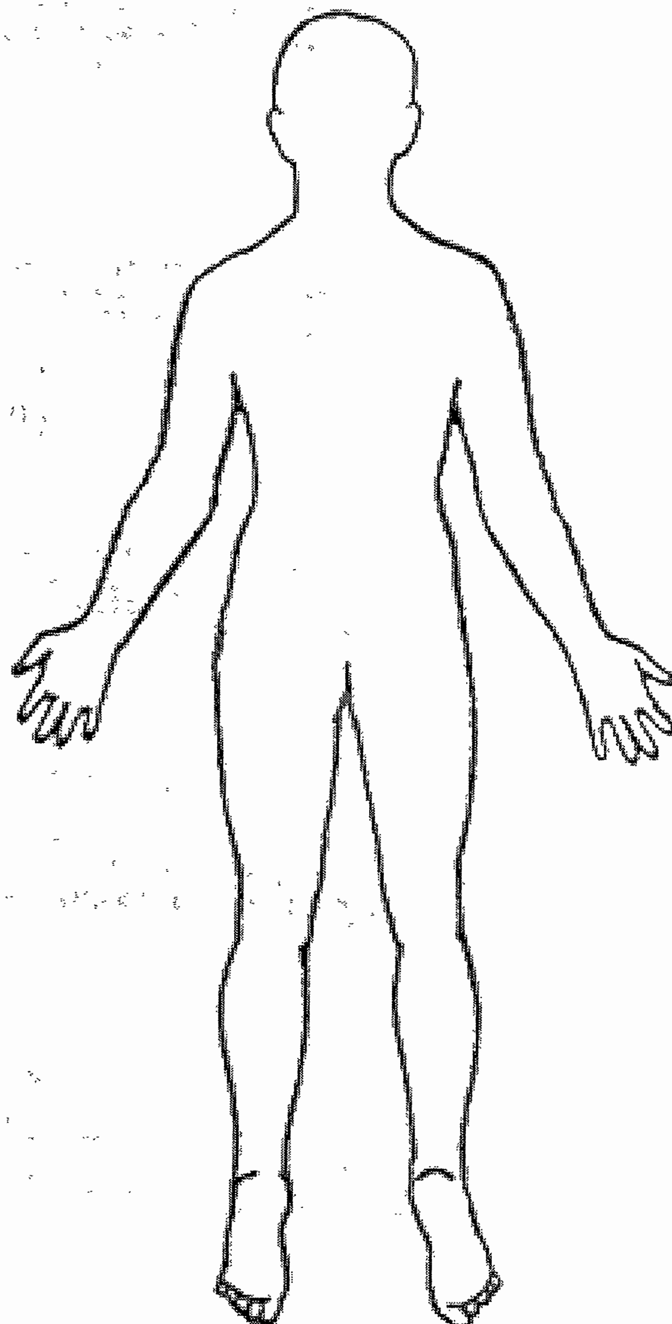
Front

Right **Left**



Back

Left **Right**



ACTIVITIES DISCOMFORT SCALE

NAME: ______________________________ DATE: ______________________________

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

	0	1	2	3	4
Activity	Doesn't Hurt	Hurts a Little	Hurts Very Much	Almost Unbearable	Unbearable
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or Jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					
Other: __________					
Totals					

COMMENTS: ______________________________

____

____

____

____

SCORE: __________

Od Mill Chiropractic
Medical Information/HIPPA Release Form

Name: ____ Date: _____________

Release of Information:

[] I authorize Old Mill Chiropractic & Physical Medicine to release information, including my diagnosis, records, examination rendered to me and claims information. This information may be released to:

[] Spouse: ____

[] Children: ____

[] Other: ____

[] Information is NOT to be released to anyone.

Messages:

Please Call: [] Home: ____________________________

[] Cell: ____________________________

[] Work: ____________________________

If unable to reach me:

[] You may leave a detailed message.
[] Please leave a message asking me to return your call.
[] Other: ___________________________________

____ ________________

Patient or Guardian Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and chiropractic procedures, including various modes of physiotherapy and diagnostic x-ray on me (or on the patient named below, for whom I'm legally responsible) by the doctor, Samuel E Durbin, D.C. or his associates, affiliated with Old Mill Chiropractic.

I understand that in the practice of chiropractic care there are some risks to treatment, including but limited to fractures, disc injuries, dislocations and sprains. I do not expect Dr. Durbin or his associates to be able to anticipate and explain all the risks and complications. I wish to rely on Dr. Durbin and associates to exercise judgement during the procedure which they feel at the time, based on the facts they know, and is in my best interest.

I have read, or have had it read to me, the above consent. By signing this below, I agree to the above, and allow Dr. Durbin and his associates affiliated with Old Mill Chiropractic to perform such. I intend this content form to cover the entire course of treatment for my present condition(s) for which I seek treatment.

______________________________ ______________________________

Patient Signature Date

____

Parent or Guardian Signature

INSURNCE AUTHORIZATION AND RELEASE

I authorize the release of any information, including the diagnosis and records of any treatment or examinations rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Old Mill Chiropractic any insurance benefits otherwise payable to me.

I understand my insurance carrier may pay less than the actual bill for medical service/supplies rendered. I agree to be responsible for payments on all medical services and supplies rendered on my behalf or my dependents.

I understand the I my ask for a copy of HIPPA NOTICE from the front desk and I consent to these policies.

______________________________ ______________________________

Patient Signature Date

____

Parent or Guardian Signature

Patient Name:________________________ Date of Birth:________________

Old Mill Chiropractic
235 Jungermann Rd., Ste. 210
Saint Peters, MO 63376
Phone: 636-352-0380
Fax: 636-352-2343
Samuel Durbin, D.C.
Daniel Coogan, D.C.

OFFICE POLICIES AND PROCEDURES FOR OUR PATIENTS

Office Hours:

Monday:	9:00am – 6:00pm
Tuesday:	9:00am—6:00pm
Wednesday:	9:00 am – 6:00pm
Thursday:	8:00am – 6:00pm
Friday:	8:00am – 2:00pm
Saturday:	8:30am—12:00pm
Sunday:	CLOSED

**Office hours are subject to change and are listed with the exception of holiday closures.*
**Lunch is taken on Monday, Wednesday, and Thursday for 1 hour per day.*
NO APPOINTMENTS WILL BE ADDRESSED AFTER HOURS.

APPOINTMENTS

Old Mill Chiropractic is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments well in advance for follow-up care. To ensure quality care, our physicians do not treat patients they have not seen and telephone consultations are not available.

In order to provide you with the best care, it is requested that you attend all scheduled appointments per your physician provided treatment plan. Our office does ask that you are on time for your appointments. If you are going to be late, please call the office to let them know. Also be aware that we cannot always accommodate late appointment arrivals therefore we may have to reschedule your appointment. Appointment times are limited and therefore we require a 24 hour notice for all cancellations.

Appointments need to be canceled within 24 hours of the scheduled time so that we can accommodate other patients. Missed appointments without prior notification ***will incur a $45* fee** charged to the credit card on file. By signing below, you authorize Old Mill Chiropractic to charge your credit card on file for any applicable fees associated with missed or late-canceled appointments.

Patient/Guardian Signature: ______________________________ ***Date***______________

INSURANCE BILLING

As a courtesy to our patients, Old Mill Chiropractic is happy to file insurance claims on your behalf. We accept most major insurance carriers. Please ask an office representative for further information. It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payments. The patient is ultimately responsible for ALL outstanding balances.

CO-PAYMENT AND DEDUCTIBLES

Patients are responsible for co-payments ***at time of service***. You will be billed for any applicable deductibles or co-insurance amounts and/or fees for services not covered by your insurance (as stated in your insurance contract) by our billing department. If we are unable to verify insurance coverage prior to your scheduled appointment, you will be responsible for fees associated with the office visit ***at the time of service***.

PAYMENTS

Old Mill Chiropractic accepts cash, checks, and all major credit cards. We will make all reasonable attempts to collect outstanding patient balances. We reserve and will exercise the right to add **a $25.00 finance charge** to accounts past due at 30 days, 60 days, and 90 days of the invoice date. Any account 90 days past due will be reported to a collections agency. All expenses incurred from the collections process will be the patient's responsibility, as permitted by law.

Bounced Check Policy

If your check bounces you are responsible for the amount of the check, **a $35.00 fee**, and all expenses incurred in the collection process to recover the original amount.

FORMS/LETTERS

We understand that at times various forms or letters may be required to assist you with your healthcare needs. Old Mill Chiropractic will be happy to complete forms and write medical letters as necessary upon request. However, because this can be time-consuming and not covered under your insurance, fees for this service will apply. While these charges may vary, they generally range from **$25-$50 per form**. Costs will be discussed ahead of time and pre-payment is required. Please allow 10-14 business days for completion of requested forms/letters.

MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to release of these materials. All patients can request a copy of their records at any time for a normal fee. Payment is required prior to records being processed. Please allow 15-30 days to complete requests for records.

____ ________________

Patient/Guardian Signature **Date**