

# Tinkle Chiropractic

212 N. 8<sup>th</sup> Street  
Richmond, IN 47374

## Welcome

On behalf of Dr. Tinkle and the staff of Tinkle Chiropractic, we would like to thank you for allowing us to provide care for you and your family. It is the intention of our office to provide thorough and efficient treatment. Service to our patients is successful when there is complete and mutual cooperation.

Would like to reiterate with you some of our office policies:

- The initial appointment is devoted to a thorough exam and possibly x-rays if needed, which are necessary to properly diagnose and recommend treatment.
- **Payment is due at the time of service unless financial arrangements are made in advance.** Payment must be made at least every 30 days.
- A 5% finance charge will be applied to accounts on any month where payment is delinquent for 30 days or more.
- Insured patients are required to supply a completed insurance form and/or card, which we may copy and keep on file.
  - Deductibles and co-pays are due at time of treatment.
  - As a courtesy to our patients the office will bill insurance claims.
  - Your insurance policy is a contract between you and your company, not with our office. ***We can only estimate your co-pay based on the information we receive from your insurance company.***

Again, thank you for understanding the necessity for these policies. If you have any concerns or questions regarding your treatment, please ask any of our staff. We are here to serve you!

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Tinkle Chiropractic Office  
 212 N. 8<sup>th</sup> Street  
 Richmond, IN 47374

NAME: \_\_\_\_\_  
 DATE: \_\_\_\_\_

**PAST MEDICAL HISTORY: CHECK (✓) IF YOU CURRENTLY EXPERIENCE**

GENERAL SYMPTOMS	EYE, EAR, NOSE, THROAT	MUSCLE & JOINT	DISEASES HISTORY
Headache	Poor vision	Weakness	Appendicitis
Fever	Cross eyed	Twitching	Pneumonia
Chills	Pain in eyes	Stiff Neck	Rheumatic fever
Night Sweats	Deafness	Backache	Polio
Fainting	Earache	Swollen joints	Tuberculosis
Dizziness	Ear Noises	Tremors	Whooping cough
Convulsions	Nasal Obstruction	Foot Trouble	Anemia
Loss of Sleep	Nose Bleed	Painful tail bone	Measles
Fatigue	Sore throats	Pain between shoulders	Mumps
Nervousness	Hoarseness	Hernia	Chicken Pox
Loss of Weight	Hay Fever	Spinal curvature	Diabetes
Numbness or pain in arms/legs/hands	Asthma	CARDIO-VASCULAR	Cancer
Allergy	Frequent Colds	Rapid or slow heartbeat	Heart disease
Wheezing	Enlarged thyroid	High/low blood pressure	Goiter
Neuralgia	Tonsillitis	Pain over heart	Influenza
Pain that wakes you up in the night	Sinus Trouble	Prev. heart trouble	Pleurisy
GASTRO-INTESTINAL	RESPIRATORY	Swelling of Ankles	Alcoholism
Poor Appetite	Chronic Cough	Poor circulation	Venereal infection
Poor Digestion	Spitting Blood or Phlegm	Varicose veins	Arthritis
Excessive Hunger	Chest Pain	Strokes	Epilepsy
Belching or Gas	Difficulty Breathing	SKIN OR ALLERGIES	Mental disorder
Nausea	GENITO-URINARY	Skin eruptions	Lumbago
Vomiting	Frequent urination	Itching	PREVIOUS INJURIES
Vomiting Blood	Painful urination	Bruise easily	Hospital. /surgeries
Pain Over Stomach	Blood in urine	Dryness	
Constipation	Kidney infection	Boils	
Diarrhea	Bed Wetting	Sensitive skin	
Colon Trouble	Inability to control	Hives or Allergy	
Hemorrhoids	Urine	Eczema	Auto Accident/Falls
Liver Trouble	Prostate trouble	Medications	
Jaundice			
Gall Bladder Trouble			Accidents on job
FOR WOMEN ONLY	HABITS	FAMILY HISTORY	
Painful periods	Smoke pks/day	Brothers	
Excessive flow	Drink alcohol	Sisters	
Irregular cycles	Coffee cups/day	(immediate family)	MEDICATIONS
Hot flashes			(Currently taking)
Cramps or backache	EXERCISE	Diabetes	
Miscarriage	None Moderate Daily	Heart	
Vaginal discharge		Kidney	
Pregnant at this time		Cancer	
Last Pap		Back	
By who			

Dr. Signature and Date: \_\_\_\_\_

## PATIENT INFORMATION SHEET

Tinkle Chiropractic  
212 N. 8<sup>th</sup> Street  
Richmond, IN 47374

### PATIENT:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_  
Gender: **M** **F** Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Children: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Work Phone \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### SPOUSE or GUARDIAN:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Work Phone \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

### EMERGENCY: (Name and Address of nearest relative or friend **not living with you.**)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_  
Home Address: \_\_\_\_\_ Apt# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_

### RESPONSIBLE PARTY: (Complete this section if you are **not** the patient, but are responsible for payment.)

Responsible party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home address: \_\_\_\_\_ Apt# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

### SIGNATURE: (Patient, parent, legal guardian or responsible party)

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance and

that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, I/we hereby guarantee payment in full of patients account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I/we agree that in the event of a default in payment, a reasonable collection agency fee equal to 50% of the delinquent balance and reasonable attorney fees, shall be added to amount due on the account, plus any applicable court costs.

If special financial arrangements need to be made please talk with the office manager at this time.

Date: \_\_\_\_\_ Signature \_\_\_\_\_

**I HEREBY AUTHORIZE THE ATTENDING DOCTOR TO RELEASE ANY INFORMATION CONCERNING MY EXAMINATION OR TREATMENT.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THIS OFFICE FOR PROFESSIONAL SERVICES RENDERED AND I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE TO THE DOCTOR.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Other methods of payment**

For the persons who do not have insurance of their Insurance carrier will not pay for chiropractic coverage, we have the following methods of payment: CASH, CHECK, MASTERCARD, AND VISA.

# Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly; please be as neat and accurate as possible while completing this form. Thank you.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

(Indicate if child, student, housewife, unemployed, retired)

Social Business Company

Sec. # \_\_\_\_\_ Phone \_\_\_\_\_ Name \_\_\_\_\_ Location \_\_\_\_\_

Spouse's Spouse's Spouse's

First Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Employer \_\_\_\_\_ Location \_\_\_\_\_

Please explain in detail how your accident happened \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_

Driver of other vehicle (if any)

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Driver of vehicle in which you were injured (if applicable)

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of your insurance adjustor \_\_\_\_\_

Have you retained an attorney?  Yes  No

If so, his name and address \_\_\_\_\_

You were heading  North  East  South  West on \_\_\_\_\_ (street or highway)

Other vehicle was headed  North  East  South  West on \_\_\_\_\_ (street or highway)

Were police notified?  Yes  No

Were you knocked unconscious?  Yes  No If so, for how long? \_\_\_\_\_

You were struck from  Behind  Front  Left side  Right side

You were  Driver  Passenger  Front seat  Back seat  Using seat belts  Other protective devices

What were the time and date of present injury? \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Was any other doctor consulted after your accident?  Yes  No

If so, what was the doctor's name? \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S.

What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see the doctor? \_\_\_\_\_

How long did you see the doctor? \_\_\_\_\_

Have you ever had any complaints in the involved area before?  Yes  No

If so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with others your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms  Improving?  Getting worse?  Same?

# Workers' Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # \_\_\_\_\_ Business Phone \_\_\_\_\_ Company Name \_\_\_\_\_ Location \_\_\_\_\_

Spouse's First Name \_\_\_\_\_ Spouse's Soc. Sec. # \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Location \_\_\_\_\_

Please explain in detail how your accident happened \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you retained an attorney?  Yes  No Litigation?  Yes  No  Maybe

If so, name and address \_\_\_\_\_

Give time and date present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_\_ 19 \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

Did you return to work?  Yes  No If so, date returned to work \_\_\_\_\_

Did you consult any other doctor?  Yes  No

If so, give doctor's name \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S.

Doctor's diagnosis \_\_\_\_\_

What treatments did you receive? \_\_\_\_\_

Have you ever injured this area before?  Yes  No If so, when? \_\_\_\_\_

If injured before, did you lose time from work?  Yes  No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted \_\_\_\_\_

\_\_\_\_\_

Do any other diseases or accidents affect your employment?  Yes  No If so, explain \_\_\_\_\_

\_\_\_\_\_

In your work do you have to favor any part of your body?  Yes  No If so, explain \_\_\_\_\_

\_\_\_\_\_

Do you have a history of absenteeism caused from accidents on the job?  Yes  No

Have you ever had a Workmen's Compensation claim before?  Yes  No

Before the injury were you capable of working on an equal basis with others your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms  improving?  getting worse?  the same?