NEW PATIENT PAPERWORK

GENERAL INFORMATION

NAME: ____ AGE: __________ SEX: Male / Female
ADDRESS: ____
CITY: ____ STATE: ________ ZIP: ____________________
CELL PHONE: ____ BIRTHDATE: _____________________________
EMAIL ADDRESS: ____
REFERRED BY: ____ PREFERRED NAME: _______________________

Please Select Payment Option: Keep Card on File At Time of Service

INSURANCE

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and I am ultimately responsible for any unpaid balances.

Patient Signature: _____________________________________ Date: ___________________________________
Insurance Company: ___________________________________ Phone: _________________________________
ID/Subscriber #: ______________________________________ Group #: ________________________________

CONSENT FOR CARE

I give the doctors, therapists and staff permission and authority to care for me in accordance with testing, diagnosis, analysis and treatment. I am responsible to inform you of any symptoms, conditions, or issues which would otherwise not come to their attention.

Patient Signature: ____ Date: __________________________
Parent/Guardian Signature: ____ Date: __________________________

HIPAA NOTICE

I acknowledge the following:

1. The privacy notice is available to me now and at any time in the future.
2. Appointment reminders may be used by the practice via email, phone or postcards.
3. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
4. I authorize the release of my medical information to the following person(s): ______________________

Patient Signature: _____________________________________ Date: ___________________________________

Woodhaven Health PC
600 Blair Park Rd. Ste 260
Williston, VT 05495
Phone: (802) 857-5099
Fax: (802) 857-5179
contact@woodhavenhealth.com

WHAT BRINGS YOU IN TODAY?

Location of pain/symptoms: ____
What would you rate your pain at its worst (1-10, ten being the worse pain possible): ____________________
Please describe the pain: ____
Any numbness or tingling: Yes / No Where: ____
Any radiating or shooting pain/symptoms: Yes / No Where: ____
When did this begin: ____
How did this happen: ____
Is this related to auto accident or work injury: Yes / No Which one: Auto / Work
What makes your pain/symptoms worse: ____
What relieves you pain/symptoms: ____
Is there a time of the day that your pain/symptoms are better or worse: ______________________________
Have you experienced these pain/symptoms before: Yes / No
When: ____
Who have you seen for this: ____
What did they do: ____
How did you respond: ____

LIFESTYLE

Do you exercise? Yes / No How often and what activities: _________________________________
Do you smoke? Yes / No How much per day: ____
Do you drink alcohol? Yes / No How much per week: ____
Do you drink caffeine? Yes / No How much per day: ____
How many cups of water do you drink per day: ____
List any vitamins and supplements: ____
List any medications: ____

HEALTH CONDITIONS

Cervical (Neck) Region:
- Neck Pain
- Headaches/Migraines
- Seizures/Epilepsy
- Pain in shoulders/arms/hands
- Dizziness
- TMJ pain/clicking
- Weakness in grip
- Numb/tingling in arms/hands

Thoracic (upper and middle back) Region:
- Upper back pain
- Middle back pain
- Pain in ribs/chest
- Pain on deep breathing

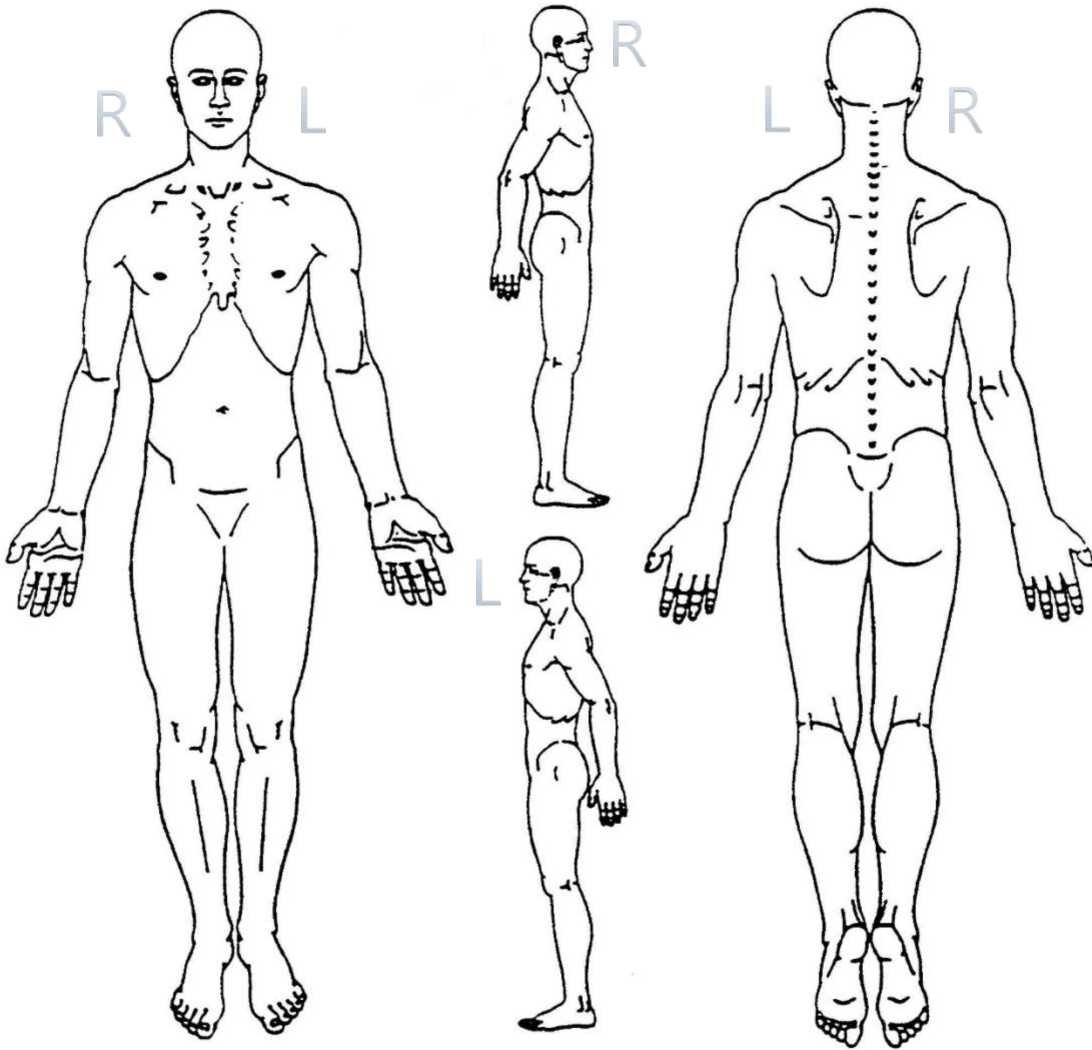
Lumbar (low back) or Pelvis (hips) Region:
- Low back pain
- Pain in hips/legs/feet
- Weak in legs/feet
- Numb/tingling in legs/feet

List any allergies: ____
____
List all surgeries with date: ____
____
List any other health condition not mentioned: ____
____

PAIN DIAGRAM

Use the symbols below to show the area, upon the body outline, in which you are experiencing pain.

Ache – A Burn – B Numbness – N Pins & Needles – P Stabbing – S Other – O



The line below represents the intensity of the pain you are experiencing. Please make an “X” at the position on the scale the indicates how much pain you are experiencing ***at this time.***

No Pain 0 ______________________________ **10 Worst Pain**

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

PATIENT INFORMATION

Last Name ____ First Name ____

CARD INFORMATION

Name as it appears on Credit/Debit Card ____

Mailing Address ____

City ____ State ______________________ Zip ___________________

CARD NUMBER ____________________ - __________________ - ___________________ - ___________________

___________ / ___________ ________________

Expiration Date CVV Code

CREDIT/DEBIT CARD AUTHORIZATION

I authorize Woodhaven Health or its authorized credit/debt card transaction agent(s) to bill my credit/debt card account indicated above for payment of each single visit charged for services & treatment that is received.

Signature: ____ Date:____________________________________

Please note: Your card billing date may not occur on your treatment date due to insurance processing times. Your charge may be up to 30 days delayed. Please contact us for further details.

RECEIPT

Please Select One:
- No receipt needed
- Yes, please email me a receipt at ____