True North Wellness LLC
Dr. Martin Petrovic, DC
truenorthwellness1.com
Phone: 503-809-0800

True North Wellness

10700 SW Beaverton-
Hillsdale Hwy, Ste 622
Beaverton, OR 97005
Fax: 971-229-4998

New Patient Registration

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: M / F Social Security #: _____ - _____ - _____

Address: _____
number street city state zip

Primary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

Secondary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

E-mail: _____ ☐ opt-in ☐ opt-out

Employer: _____ Occupation: _____

Primary Physician's Name: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Who may we thank for referring you? _____

Payment Information

☐ I will pay my balance in full at time of service (this includes Groupon, gift certificate, etc.)
☐ I prefer to make payment arrangements prior to services being rendered
☐ I intend to bill insurance (auto accident, workers comp, health insurance, superbill):

Name of Insured _____ Relationship to Patient: _____

Insurance Company: _____ Group #: _____

Claim / ID#: _____ Date of collision/work injury: _____

Representative name: _____ Claims Phone: (_____) _____ - _____

Payment Policy

By signing below, I understand that full payment for all services and products I receive from True North Wellness LLC is required at the time of service, except that portion billed to my insurance company. I understand that True North Wellness LLC may bill my insurance carrier directly, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance, or deductible required by my insurance. I instruct my insurance carrier to pay this office directly for all services and authorize the release of any information necessary to secure payment.

By signing this form I affirm that I have given true and complete information.

Signature (Patient or Guardian) Date

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Financial Policy, HIPAA, & Chiropractic Care Consent Form

Clinic Financial Policy

Insurance Plans Billed: ASH (Aetna, BCBS, Cigna, Health-Net, Providence), Pacific Source, United Healthcare, Regence
Time of Service Fees: We offer an affordable discount for same day payment for services performed.
Missed Appointments or Late Cancellations: 24 hours' notice is required; $35 cancellation fee applies.
Personal Injury Claims & Billing

- Auto accident and worker's comp related injuries require verification of an existing claim prior to examination and treatment.
- _____ If examination and treatment for auto and work-related injuries is not covered by any or all personal injury insurance companies involved, I, the patient, am responsible for all fees for treatment.

_____ I, the patient, am responsible for paying all out-of-pocket costs which may include time-of-service fees, co-pays, or co-insurance. For insurance companies that True North Wellness LLC is not contracted with, a Super Bill/Invoice will be provided upon request which can be submitted to insurance plans for potential reimbursement.

HIPAA Notice of Privacy Practices

Your protected health information may be used and disclosed by your physician, our staff, and others outside of this office that are involved in your care for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. All your information is strictly confidential.

_____ I, the patient, consent to the use and disclosure of my Protected Health Information by True North Wellness LLC.

Examination & Treatment Consent

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound/laser, heat/ice application, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications such as stroke are estimated to be in the range of 0.5 - 2 incidents per million for adjustments of the neck, and 1 per million for adjustments of the low back.

_____ I, the patient, have read and understand the above statements regarding treatment side-effects. I was made aware of procedures, alternative treatments, risks, and I was provided the opportunity to ask questions regarding recommended treatment(s) &/or procedure(s). I also understand that there is no guarantee or warranty for a specific cure or result.

Please read the following carefully and initial:

- _____ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, pacemaker, etc.), I should discuss this with the physician because it may affect care.
- _____ Notice to pregnant women: all females must alert their doctor if suspecting or having confirmed pregnancy as some therapies prescribed could present a risk to the pregnancy.
- _____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, True North Wellness LLC reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with payment and/or reasonable treatment plans.

By signing this application, I affirm that I have given true and complete information.

_____ _____ _____/_____/_____
Print Name Signature Date

_____ _____/_____/_____
Physician Signature (Dr. Martin Petrovic or relief doctor) Date

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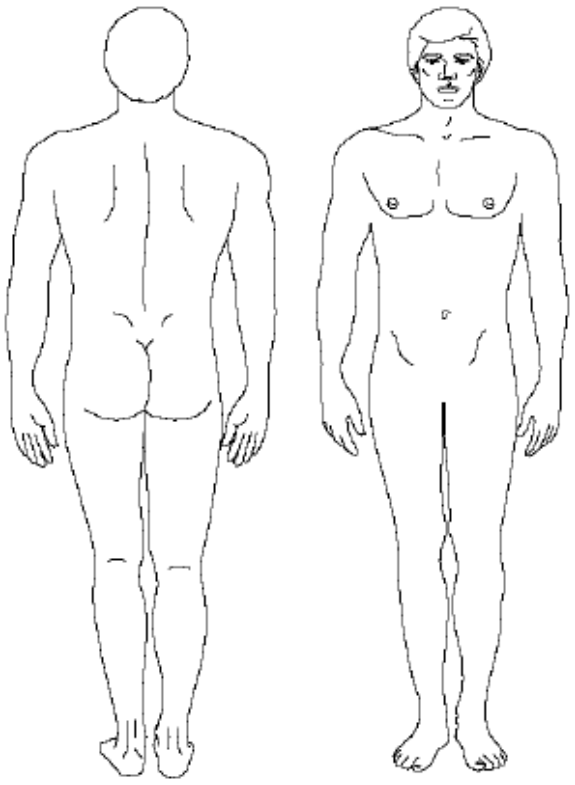
PATIENT INITIAL INTAKE

Patient Name: _____ DOB: _____ Date: _____

Describe your symptoms: _____
_____
_____
_____

Indicate the location of your symptoms:



Describe any activities affected by your symptoms:
_____
_____

When did your symptoms begin? _____
_____

Are your symptoms getting worse? ☐ No ☐ Yes
Does it keep you from working? ☐ No ☐ Yes
Does it keep you from sleeping? ☐ No ☐ Yes

Have you seen a chiropractor before? ☐ No ☐ Yes
Are you under the care of a physician? ☐ No ☐ Yes
Name of physician: _____

Please list current medications and reasons for taking them:
_____
_____

Have you ever experienced:	No	Yes	If yes, briefly explain:
broken bone	☐	☐	_____
hospitalization/surgery	☐	☐	_____
strains/sprains	☐	☐	_____
fallen/struck unconscious	☐	☐	_____
auto collision/work injury	☐	☐	_____

Please list any other health conditions (10 years): _____
_____
_____

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine
☐ Stress level

Packs/day _____
Drinks/week _____
Cups/day _____
Reason _____

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REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ Date: _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please indicate all CURRENT or PAST conditions. To be responsible for your case, we need your complete health history.

C = Current problem P = Past problem

C	P	Muscle / Joint
☐	☐	Neck pain, stiffness
☐	☐	Pain b/t shoulders
☐	☐	Low back pain
☐	☐	Sciatica
☐	☐	Painful tailbone
☐	☐	Poor posture
☐	☐	Spinal curvature
☐	☐	Foot trouble
☐	☐	Swollen joints
☐	☐	Bursitis

C	P	Pain
☐	☐	Headache
☐	☐	Eye
☐	☐	Ear
☐	☐	Abdomen
☐	☐	Chest
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Elbows
☐	☐	Forearm
☐	☐	Hand
☐	☐	Hips
☐	☐	Thigh
☐	☐	Knee
☐	☐	Shin
☐	☐	Ankle
☐	☐	Feet

C	P	Numbness
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Forearm
☐	☐	Thigh
☐	☐	Shin / calf
☐	☐	Feet
☐	☐	Hands

C	P	General
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Concussion
☐	☐	Allergy
☐	☐	Skin rash
☐	☐	Enlarged glands

C	P	Cardiovascular
☐	☐	Hardened arteries
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Pain over heart
☐	☐	Poor circulation
☐	☐	Rapid heartbeat
☐	☐	Slow heartbeat
☐	☐	Swelling of ankles

C	P	Gastrointestinal
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Jaundice
☐	☐	Liver trouble
☐	☐	Nausea
☐	☐	Vomiting

C	P	Genitourinary
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Lose bladder control
☐	☐	Kidney infection
☐	☐	Painful urination
☐	☐	Prostate trouble

C	P	WOMEN ONLY:
☐	☐	Congested breasts
☐	☐	Lumps in breast
☐	☐	Menstrual pain
☐	☐	Irregular cycle
☐	☐	Excessive flow
☐	☐	Hot flashes
☐	☐	Menopause

C	P	Respiratory
☐	☐	Chronic cough
☐	☐	Difficult breathing
☐	☐	Spit up blood

Check any conditions you have presently OR have had in the past:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Pacemaker (or other medical implant): ☐ No ☐ Yes **Pregnant**: ☐ No ☐ Yes ☐ Planning

Please list any family history of serious illness (i.e. heart disease, stroke, cancer, diabetes):

_____

_____

_____

Patient or Guardian Signature: _____ Date: _____