Welcome

Lott Chiropractic Clinic, P.C.
Dr. Gregory Lott
(402) 489-0777

Patient Name: _____ **SSN (required)** _____
Address: _____City/ST/Zip: _____
Cell Phone: _____ Home Phone: _____
Employer/Occupation: _____ Work Phone: _____
Email: _____ Date of Birth: _____ Gender: M F
Spouse/Partner's Name and Phone: _____

- Emergency Contact Name & Relationship: _____
- Emergency Contact Phone: _____

How did you hear about us? Existing Patient/Name: _____ Other: _____
WOMEN ONLY: To the best of your knowledge, are you currently pregnant? ___ No ___ Yes, Due Date: _____

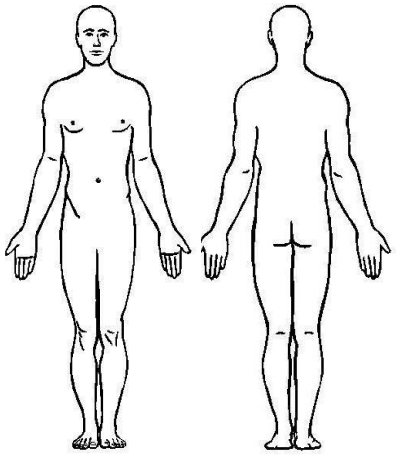
INSURANCE *PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK STAFF, SO THAT WE MAY MAKE A COPY*

Primary Insurance Company: _____ **ID**: _____
Group ID: _____
Secondary Insurance Company: _____ **ID:** _____
Group ID: _____
*If the primary insured is someone **other** than the patient:* **Name of Insured**: _____
Relationship to Insured: ☐ Spouse ☐ Child ☐ Other **Insured's Birth Date**: _____
Insured's Address: _____

Are you seeking treatment for an injury sustained in a Motor Vehicle or Work-Related Accident? ☐ No ☐ Yes
If YES, please speak to the front desk staff so that we can collect the appropriate additional information from you.

CURRENT CONDITION

Mark your areas of discomfort



1. **Describe your current condition:** _____
   Secondary Condition: _____
2. **When did your symptoms appear?** _____
3. **Are your symptoms**: ☐ Getting Worse ☐ Spreading ☐ Improving ☐ Unchanged
4. **Mark the severity of your pain on the scale:**
   No Pain *Mild* *Moderate* *Severe* *Intolerable*
5. **Type of Pain:** ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
   ☐ Shooting ☐ Burning ☐ Cramps ☐ Tingling ☐ Stiffness ☐ Swelling
6. **How often do you have this pain?** ☐ Constant ☐ Frequent (~ 75% of the time)
   ☐ Intermittent (~ 50% of the time) ☐ Occasional (~ 25% of the time)
7. **Which activities Provoke or Aggravate your condition?** ☐ Sitting ☐ Walking ☐ Lying Down ☐ Hot/Cold
   ☐ Pushing ☐ Pulling ☐ Lifting ☐ Gripping ☐ Coughing/Sneezing ☐ Bending ☐ Bright Lights
8. **Which activities help to Lessen your pain**? ☐ Lying Down ☐ Sitting ☐ Walking ☐ Standing ☐ Resting
   ☐ Massage ☐Hot/Cold ☐ Stretching ☐ Darkness/Quiet ☐ Medications Other: _____
9. **Which treatment(s) have you already received for your current condition**? ☐ Medications ☐ Surgery
   ☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ None Other: _____
10. **Name and Address** of other doctor(s) who have treated you for this condition (if applicable) _____

PHYSICIANS & MEDICAL HISTORY

Family Physician: _____ **Medical Specialist(s)**: _____

Have you previously received Chiropractic Care? ☐ No ☐ Yes, with Dr. _____

Injuries, Accidents, Falls/Traumas: ☐ No ☐ Yes, _____

Illnesses/Hospitalizations: ☐ No ☐ Yes, _____

Surgeries: ☐ No ☐ Yes, _____

X-rays, MRI, CT or Other Imaging: ☐ No ☐ Yes, _____

Other Conditions the Doctor should know about: _____

PERSONAL HABITS

Tobacco: ☐ None ☐ Yes, ____ Packs/Cans per Week **Sleep**: ☐ None ☐ Yes, ____ Hours/Night

Alcohol: ☐ None ☐ Yes, ____ Drinks/Week **Coffee**: ☐ None ☐ Yes, ____ Cups/Week

Water: ☐ None ☐ Yes, ____ Ounces/Day **Soft Drinks**: ☐ None ☐ Yes, ____ Bottles/Cans per Week

Recreational Drugs: ☐ None ☐ Yes, Type: _____ , Frequency: _____ , Years of Use: _____

Exercise: ☐ None ☐ Yes, ____ Hours/Week; **What type of exercise?** _____

Eating: ____ Meals/Day; **What types of food do you eat primarily?** _____

HOW WOULD YOU DESCRIBE YOUR CURRENT…

Emotional State:	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Concentration:	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise Level:	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits:	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health:	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Financial, Insurance and Privacy Policy

- **I understand that I am financially responsible for all charges, whether or not paid by insurance and I authorize the use of my signature on all insurance submissions.**
- Dr. Lott may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Further, I understand that it is my responsibility to keep Dr. Lott and his staff apprised of any changes in insurance coverage.
  - If there is a lapse in my insurance coverage, I understand that I am responsible for any fees incurred.
- If ever I elect not to furnish insurance information for the submission of claims relating to my treatments, I realize that I am financially responsible for any and all treatments that I receive while under the care of Dr. Lott.
- I also understand that I have the option of paying fully at the time of service. If I choose the Time-of-Service option, the services and treatments I receive from Dr. Lott are not allowed to be submitted to any insurance company for reimbursement, either by myself or any agent acting on my behalf.
  - I further understand that the Time-of-Service option **requires payment at the time-of-service.**

- We do not provide your personal information to unauthorized persons or organizations outside of our clinic.
- We do not share your medical information with anyone unless you authorize it or we are authorized or required by law to do so.
  - We maintain safeguards to protect your information, physically and electronically.
- We may contact you using your phone numbers or email addresses you provide to us. By supplying this information, you agree that Dr. Lott and his staff are at liberty to leave messages, which may contain information related to your healthcare.

Do You Need to Review a Complete Copy of the HIPAA Policy: _____ *NO* _____ *YES*

"These OTHER contacts may receive my Personal Health, Billing/Insurance and Contact information when necessary."

Contact Name: _____ Contact Phone: _____

Contact Name: _____ Contact Phone: _____

By signing this form, I declare that I am aware of Lott Chiropractic Clinic, P.C.'s Financial, Insurance and Privacy Policies.

Patient/Guardian: _____
PRINTED

Patient/Guardian Signature: _____ **Date**: _____