



Frontier Integrated Health Center, Inc
 2011 Hwy K
 O'Fallon, MO 63366
 Dr. R. James Ottomeyer III



New Patient Information

PERSONAL INFORMATION

Date: _____
 Last Name: _____ First Name: _____ M.I.: _____
 Street: _____ Email Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: _____ 2nd Home Phone: _____
 Social Security Number: _____ Birth Date: _____ Current Age: _____
 Sex: Male Female Student Status: Non Full time Part time
 Marital Status: Married Single Widowed Divorced Number of Children: _____
 Occupation: _____ Employment Status: Full time Part time
 Employer Name: _____ Work Phone: _____
 Employer Street: _____ 2nd Work Phone: _____
 Employer City: _____ Employer State: _____ Employer Zip Code: _____
 Spouse Name: _____ Employer: _____ SS#: _____
 Medical Physician's Name: _____
 Previous Chiropractor's Name: _____

HOW DID YOU HEAR ABOUT FRONTIER INTEGRATED HEALTH CENTER

Referred By: _____
 Family Friend Co-Worker Attorney Yellow Pages Mail Coupon
 Newspaper Direct Mailer Friend of Doctor Street Sign Other: _____

INSURANCE INFORMATION (If you attach insurance card it is not necessary to fill out the insurance information section)

Primary Insured: _____ Insurance Company: _____
 Policy Number: _____ Group Number: _____
 Patients Relationship To Primary Insured: Self Spouse Child Other: _____
 Secondary Insurance Company: _____ 2nd Policy Number: _____

HISTORY OF COMPLAINT (Please be brief)

Present Complaint: _____
 This Condition Is Due To: Work Accident Auto Accident Home Accident
 Other: _____
 Date Symptoms Appeared/Accident Occurred: _____ Gradual Sudden
 Have You Had Similar Symptoms Previous To This Incident? Yes No Date: _____
 Have You Been Unable To Work Due To This Incident? Yes No
 Dates Missed Work From: _____ To: _____
 Have You Been Hospitalized Due To This Incident? Yes No Place/Dates: _____
 Have You Had X-Rays Taken Due To This Incident? Yes No Place/Date: _____
 Results: _____

HISTORY OF COMPLAINT CONTINUED... Patient Name: _____

Is this condition getting progressively worse or better? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying Down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling

Cramping Stiffness Swelling Other _____

Rate the severity of your pain (1=mild pain/discomfort to 10=severe/excruciating pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

If it comes and goes, how often does it come? 0-25% 25%-50% 50%-75% 75%-100% of awake time

What treatment have you already received for your condition?

Medication Surgery Chiropractic Care Physical Therapy Other _____

What makes your pain feel better? _____

What makes your pain feel worse? _____

Does the pain interrupt your sleep? Yes No Sleep Position: Stomach Back Side: Right or Left

Have you ever had a Bone Density Test Perform? _____ If so When: _____

HEALTH HISTORY *check only those conditions which are applicable:*

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____ | | |

Dates of last exams _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list ALL medications you are currently taking: _____

Vitamin/Minerals/Nutritional

Supplements _____

Allergies: _____ Smoker Yes No

DAILY ACTIVITIES

Work Requirements: sitting standing walking light labor heavy labor computer work

Daily Exercise: None Moderate Heavy Type of Exercise: _____

Any limitations with job/activities/hobbies due to pain? _____

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

Patient Data

First Name Last Name Date Email*

* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

Mailing address

Address City State Zip

Telephone (Work) (home) Referred By

Age Birth Date Social Security # Number of Children

Occupation Employer

Marital Status Spouse's Name Spouse's Occupation

Spouse's Employer Spouse's Health Status

Emergency Contact Phone

Current Complaints

Nature of Injury: Automobile* Work Other

Please describe:

Date of Injury Date symptoms appeared

Have you ever had same condition? No Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? No Yes

If yes, please describe

Insurance Information

Name of party responsible for payment Phone

Do you have health insurance? No Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name Contact Person

Phone: Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

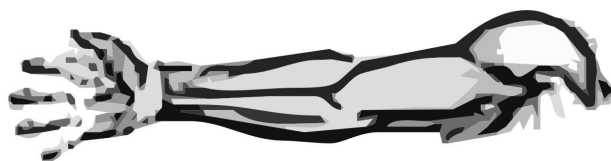
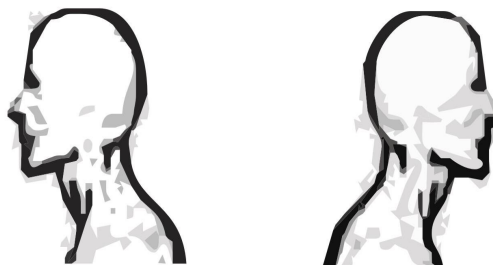
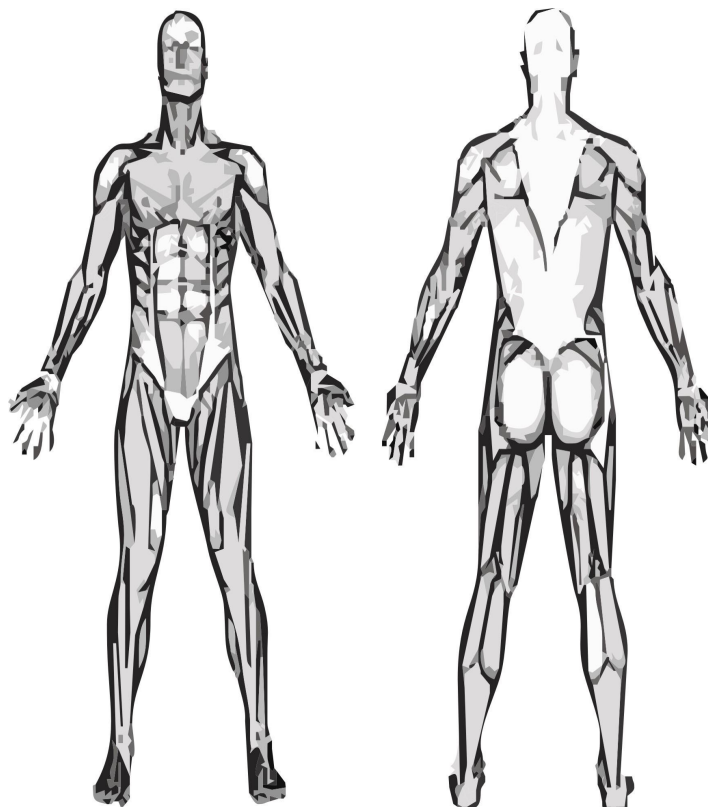
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing



OUR MISSION STATEMENT

Our MISSION is to provide the best care possible to every patient, regardless of race, creed, religion, social background or sexual orientation which is accomplished by supporting our staff and providers in every way possible to allow them to practice efficiently and dedicate their time to the individual needs of the patient.

HEALTH CARE PRIVACY NOTICE

This office is committed to providing patients with quality health care services delivered with this office is committed to providing patient commitment requires the efforts of commitment requires the efforts of the doctors, therapists, commitment requires the efforts of the results. Patient satisfaction is a vital interest to The Health Centers.

This Facility is required by This Facility is required by law to abide by the terms of this Health Care Privacy state laws governing privacy practices in health care. Our Facility may change any anytime without additional notice to you except to publically post in our Facility and/or make available anytime without additional notices. Photocopy of this Notice is available to you upon request. The term Facility notices. Photocopy of this Notice is Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected Our Facility & staff are committed to maintain about you, including demographic information, that about you, including demographic information, that may identify you as a physical or mental health or condition and the care and treatment physical or mental health or condition and the care and medical information about you may be used and disclosed and how you can obtain access to this information. See Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed in your written authorization by the doctors and staff of this Facility for the purposes of your care and health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care information. The request must be in writing, allowing your provider to charge a copy fee, which will be in compliance with applicable law. Your provider will comply with any reasonable request to have confidential communication with you at a location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This amendment may mean that anything will be removed, or changed and the provider has the right to deny the amendment if it feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider feels it is necessary as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer. Complaints must be filed within 180 days of when you knew or should have known of the violation. Prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more comprehensive Health Care Privacy Notice is available for your review in this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably assign, the assignee, being the patient and give a full and give a full lien to the office named above and listed below, hereinafter referred to as the Facility, all insurance benefits, proceeds of any settlement, judgment or verdict which may be received by me or my minor for injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party, the assignee further authorizes the Facility all sums of money due them for any & all services rendered to me or minor by whom I am insured, and to withhold such sums from a health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions, and other information to said health care provider which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care provider to any insurance company, adjuster, attorney or legal service bureau. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks, notes, and other instruments including any fee reduction and/or provider discounts.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, coAssignee agrees that this Facility & staff may deliver medical records to be paid in full in advance and authorizes this Facility to be paid in full in advance and authorizes adjuster, attorney or legal adjuster, attorney or legal service bureau to facilitate collections under the terms of this adjuster, attorney or legal attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness of attorney to endorse &/or sign my name on any for this facility are granted permission to wave all insurance provider contractual obligations, including any fee reduction or discounts

INSURANCE BENEFITS - CREDIT POLICIES - PAYMENT TERMS & CONDITION

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person. Your insurance company quote of benefits does not guarantee payment on any claims incurred by this or any facility. Benefits are determined when claims are processed and paid by the insurance carrier.

Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charge which you are responsible to pay.

Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.

Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.

All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below. I fully understand that if there is a 3rd party payer or responsible party that I have given permission for Frontier Integrated Health Center, Inc. and all providers for this facility to wave all Insurance provider contractual obligations, including any fee reduction and or provider discounts when concerning the full recovery of the fees for the provided services. Our office is not responsible for filing claims with your secondary health insurance.

A non-discriminatory Time of Service Discount is offered to anyone who pays for services the day they are rendered. The TOS is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.

A service charge is computed by a periodic rate of 11-1/2 % per month 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30.00 charge.

Patients are eligible for a maximum \$250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received my request of this document including the Health Care Privacy Notice, Informed Consent and fully understand and have had all of my questions answered. This document shall be considered as effective and valid as an original.

Print Name of Patient _____

X Signature (if minor, parent must sign)

Date
