DAVID W. BUNGANICH, D.C.
166 COHASSET ROAD, SUITE 6
CHICO, CA 95926
530-894-7261

PATIENT INFORMATION

Name_____Email_____

Home address_____City_____Zip_____

Mailing address_____City_____Zip_____

Phone/Cell_____S.S.#_____Driver license #_____

Age_____Birth date_____Sex M F Height_____Weight_____Marital status S M W D

Your occupation_____Employer_____

Work phone_____Employer's address_____

Spouse's name_____Spouse's social security #_____

Spouse's employer_____Spouse's work phone_____

Spouse's employer's address_____Spouse's occupation_____

Your family physician_____Phone number_____

Were you referred here? ( ) Yes ( ) No By whom?_____May we send a thank you?_____

Please tell us why you are here today_____

_____

_____

Is your condition due to an accident? ( ) Yes ( ) No Did your accident occur at work? ( ) Yes ( ) No

Were you involved in a motor vehicle accident? ( ) Yes ( ) No Date_____ Time_____ a.m./p.m.

Description of accident and location (include details)_____

_____

_____

Name of person responsible for payment_____

Name of insurance company (if any)_____Policy #_____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will assist in preparation of any necessary reports and forms to help me in making collection from the insurance company, and that any amount authorized to be paid directly to David W. Bunganich, D.C. will be credited to my account upon receipt. *However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.* I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I also authorize the release of any medical or other information necessary to process any insurance claim filed on my behalf by this office.

Patient's (guardian's) signature_____Date_____

DAVID W. BUNGANICH, DC

166 Cohasset Road, Ste.6
Chico, CA 95926

Patient Health Questionnaire

Patient Name:_____Patient ID#_____

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column.* If you are *presently* troubled by a particular symptom, check that symptom in the *Present Column.* **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
__	__	Neck pain
__	__	Shoulder Pain -R_____ L_____
__	__	Pain in Upper Arm or Elbow -R_____ L_____
__	__	Hand Pain - R____L____
__	__	Wrist Pain - R____L____
__	__	Upper Back Pain
__	__	Low Back Pain
__	__	Pain in Upper Leg or Hip - R____L____
__	__	Pain in Lower Leg or Hip - R____L____
__	__	Pain in Ankle or Foot - R____L____
__	__	Jaw Pain
__	__	Swelling, Joint Stiffness
__	__	Fainting
__	__	Visual Disturbances
__	__	Convulsions
__	__	Dizziness
__	__	Headache
__	__	Muscular Incoordination
__	__	Tinnitus (Ear Noises)
__	__	Rapid Heart Beat
__	__	Chest Pains
__	__	Loss of Appetite
__	__	Anorexia
__	__	Abnormal weight gain
		___gain ___loss
__	__	Excessive Thirst
__	__	Chronic Cough
__	__	Chronic Sinusitis
__	__	General Fatigue
__	__	Irregular Menstrual Flow
__	__	Profuse Menstrual Flow
__	__	Breast __Soreness __ Lumps
__	__	Endometriosis
__	__	PMS
__	__	Loss of Bladder Control
__	__	Painful Urination
__	__	Frequent Urination
__	__	Abdominal Pain
__	__	Constipation/Irregular bowel habits
__	__	Difficulty in Swallowing
__	__	Heartburn/Indigestion
__	__	Dermatitis/Eczema/Rash

Past	Present	Condition
__	__	Depression
__	__	Aortic Aneurysm
__	__	High Blood Pressure
__	__	Angina
__	__	Heart Attack - date_____
__	__	Stroke - date_____
__	__	Asthma
__	__	Cancer - explain_____
__	__	Tumor - explain_____
__	__	Prostate Problems
__	__	Blood Disorder
__	__	Emphysema (chronic lung disease)
__	__	Arthritis
__	__	Rheumatoid Arthritis
__	__	Diabetes
__	__	Epilepsy
__	__	Ulcer
__	__	Liver/Gallbladder problems
__	__	Kidney Stones
__	__	Hepatitis
__	__	Bladder Infection
__	__	Kidney Disorders (by condition)
__	__	Colitis
__	__	Irritable Colon
__	__	Other_____

If a family member has had any of the following, please mark the appropriate box:

__ Cancer
__ Rheumatoid Arthritis
__ Diabetes
__ Heart Problems
__ Lung Problems
__ High Blood Pressure

__ Epilepsy
__ Chronic Back Problems
__ Chronic Headache
__ Lupus
__ Other_____

YES	NO	
__	__	Do you have a permanent disability rating? Location_____
__	__	Date rating received___/___/_____
__	__	Rating Percentage_____%

Present Weight _____pounds **Height**_____feet_____inches

Please check any of the following that apply to you:

Past	Present	
__	__	Pregnancy/# of births_____
__	__	Birth Control Pills, type_____
__	__	Medications_____
__	__	Hospitalization/Surgeries_____
		_____

Past	Present	
__	__	Tobacco
__	__	Alcohol
__	__	Drug or Alcohol Dependence
__	__	Coffee/Tea/Caffeine Drinks cups/cans per day_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverages in the future.

Patient's Signature_____**Date**_____

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OFFICE FINANCIAL POLICY

CASH ACCOUNTS

Patients who do not have any form of insurance will be expected to pay for services when they are rendered unless other arrangements have been made in advance. We will accept monthly payments in certain cases.

PRIVATE INSURANCE

As a courtesy, we will bill your insurance company for you. You must provide us with recent insurance information on your first visit here. You will be responsible for payment of all deductibles and co-payments, as well as non-covered services.

Dr. Bunganich is a Preferred Provider with may health insurance plans including Blue Cross, Blue Shield, and ASHP which contracts with Health Net, Pacificare, Kaiser and many others. Please remember that your insurance policy is a contract between you and your insurance company. If your insurance company refuses to pay your bill for any reason, you will be responsible for the balance.

WORKERS' COMPENSATION

We require authorization from your employer before treatment is rendered. Once treatment is authorized, we will prepare all necessary reports and billings for your workers' compensation insurance company. If at any time after initiating treatment it is determined that your injury was not work related, you will be responsible for payment of your account in full.

MEDICARE

There are chiropractic benefits under the Medicare program and we accept Medicare assignment. We will bill all treatment to Medicare and your secondary insurance, if necessary. There are special rules involving Medicare, so please ask if you have any questions.

AUTO INSURANCE

If you have been injured in an auto accident, regardless of who is at fault, and have medical payment coverage in your policy, we will prepare all necessary reports and bill your auto insurance company. In special cases, we will work with your attorney, if you have one, and accept a lien pending the settlement of your case.

ALL PAST DUE ACCOUNTS OVER 90 DAYS ARE SUBJECT TO A 4% MONTHLY BILLING FEE.

I have read and understand the above, and have received a copy of these guidelines.

Signed_____ Date_____

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HIPAA CONSENT FORM

I give this practice/clinic my consent to use or disclose my personal health information to carry out my treatment, to obtain payment from insurance companies and for health care operations such as quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ _____

Signature of Patient (or Patient Representative) Date

_____

Relationship of Patient Representative

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Bunganich Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Bunganich Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient or Guardian's Signature **Date**

_____

Patient's Name (Please Print)