

**Personal Profile**

Name \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female DOB: \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_  
Who referred you to us? \_\_\_\_\_ What is your insurance? \_\_\_\_\_  
Who is your employer? \_\_\_\_\_ What is your occupation? \_\_\_\_\_  
Give a brief job description \_\_\_\_\_  
Are you working? (circle one) Full-time Part-time Unemployed

**Injury Profile**

What area of your body are you being seen for? (circle all that apply)

- Neck                      Shoulder                      Elbow                      Wrist                      Hand
- Upper Back              R L                      R L                      R L                      R L
- Low Back              Hip                      Knee                      Ankle                      Foot                      Other \_\_\_\_\_

Date of Injury \_\_\_/\_\_\_/\_\_\_ Was this caused by a motor vehicle accident? Y N Was it work-related? Y N

When did you first notice your symptoms? \_\_\_\_\_

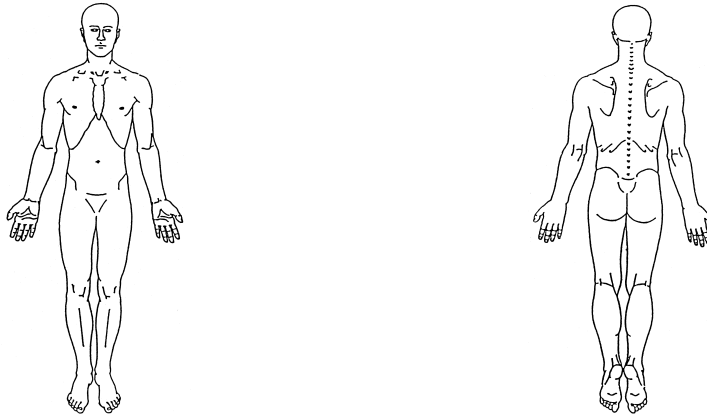
Briefly describe the injury or onset of symptoms \_\_\_\_\_

Have you injured this area previously? Y N When, and how? \_\_\_\_\_

Circle any words that describe your pain or symptoms:

- Sharp                      Tingling                      Burning                      Sore                      Dizziness                      Headaches
- Dull                      Numbness                      Cramping                      Weak                      Nausea                      Arm/hand symptoms
- Shooting                      Aching                      Tight                      Fatigued                      Ear ringing                      Leg/foot symptoms

Place an "x" on the diagram below in the location(s) where you experience pain or other symptoms



Circle how often or when you experience pain: Worse in Morning Evening Night Constant  
Sitting/Standing Walking With movement activity

Circle your average daily pain rating (1 is the least and 10 is the worst) 1 2 3 4 5 6 7 8 9 10

What activities increase or cause your pain/symptoms? \_\_\_\_\_

What activities decrease or relieve your pain/symptoms? \_\_\_\_\_

What exercises or activities do you enjoy? \_\_\_\_\_

What exercises or activities are you unable to do because of pain? \_\_\_\_\_

What is your primary objective or goal for your treatment? \_\_\_\_\_

How will you define treatment success? Freedom from all pain. Y N Doing all desired activities Y N  
Any amount of pain relief Y N Tolerating simple activities Y N

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medications (please attach detailed list if more room is needed)**

Current Pain Medications (include dosages)	Past Pain Medications (include dosages)	Other Medications (include dosages)	Vitamins / Supplements (include ingredients & dosages)

**Note: Please bring all medications & nutritional products with you if you are unsure of what you are taking**

Do you have any known allergies to any medications / substances? \_\_\_\_\_

**Previous Treatments / Diagnostic Testing**

Name any physicians/specialists you have seen for this condition \_\_\_\_\_

X-rays, MRI, and other tests results & dates [Note: Please fax or bring these reports with you to your appointment]

Circle all treatments you have received in the past for this condition:

Treatment	Approximate Date	Response to treatment
Physical Therapy		
Chiropractic care		
Massage		
Acupuncture		
Cortisone Injections		
Other		

List any pertinent surgeries and the date of the procedure.

1. \_\_\_\_\_ / /      3. \_\_\_\_\_ / /  
 2. \_\_\_\_\_ / /      4. \_\_\_\_\_ / /

**Social / Health Profile** Marital Status?    Single    Married    Widowed    Divorced      Number of children? \_\_\_\_

Do you smoke? Y    N    If so, how many packs per day? \_\_\_\_      Do you drink? Y    N    If so, how often/how much? \_\_\_\_\_

Circle any history of the following conditions in your health or your immediate family's health history & state who has the condition.

Heart Disease    who? \_\_\_\_\_      Cancer: What kind? \_\_\_\_\_ who? \_\_\_\_\_  
 Stroke    who? \_\_\_\_\_      High Blood Pressure: Is it under control ? Y    N    who? \_\_\_\_\_  
 Other \_\_\_\_\_      Diabetes: Is it under control? Y    N    who? \_\_\_\_\_

**System Profile** Circle any symptoms you have been experiencing

- |                            |                   |                     |                     |                |      |
|----------------------------|-------------------|---------------------|---------------------|----------------|------|
| 1. Unexplained weight loss | Fever             | Night Sweats        | Chills              |                |      |
| None                       |                   | 2.                  | Headaches           | Blurred Vision |      |
| Dizziness                  | Hoarse Voice      | Ringing in the ears | None                |                |      |
| 3. Chest Pain              | Irregular Pulse   | Fast or Slow Pulse  | Heart Palpitations  | Heart Burn     | None |
| 4. Chronic cough           | Sore Throat       | Excess Phlegm       | Shortness of Breath |                | None |
| 5. Diarrhea                | Ulcers            | Constipation        | Nausea              | Blood in Stool | None |
| 6. Difficulty Urinating    | Painful Urination | Frequent Urination  | Blood in Urine      |                | None |
| 7 Hot/Cold Hands & Feet    | Skin Rash         | Dry Skin            | New Moles           | Easy Bruising  | None |

Please comment on any other health issue that should be brought to our attention:

\_\_\_\_\_

# HEALTH SYSTEM SURVEY

Patient Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you taken phen-phen in the past? \_\_\_\_ Yes \_\_\_\_ No

In the last year, have you experienced any of the following problems?  
(Check any/all that you have experienced)

- \_\_\_\_\_ Compulsivity (including compulsive eating)
- \_\_\_\_\_ Depression
- \_\_\_\_\_ Anxiety
- \_\_\_\_\_ Panic Attacks
- \_\_\_\_\_ Impulsivity
- \_\_\_\_\_ Obsessionality (OCD)
- \_\_\_\_\_ Bipolar disorder
- \_\_\_\_\_ Mania (uncontrolled/sudden emotions)
- \_\_\_\_\_ Aggression
- \_\_\_\_\_ Self-Injury
- \_\_\_\_\_ Increased hunger and weight gain after dieting
- \_\_\_\_\_ Anorexia
- \_\_\_\_\_ Bulimia
- \_\_\_\_\_ Myoclonus (twitching muscles or legs)
- \_\_\_\_\_ Irritable Bowel Syndrome (IBS)
- \_\_\_\_\_ Migraine Headaches
- \_\_\_\_\_ PMS (Pre-menstrual Syndrome)
- \_\_\_\_\_ Fibromyalgia
- \_\_\_\_\_ Temporomandibular joint syndrome (TMJ Syndrome)
- \_\_\_\_\_ Chronic Pain States
- \_\_\_\_\_ Sleep Apnea
- \_\_\_\_\_ Insomnia (Average 4 hours or less with multiple wake-ups)

**Patient Information**

**Personal Information**

Name \_\_\_\_\_  
Last First M.I.

DOB \_\_\_ / \_\_\_ / \_\_\_ Marital Status S M W D

SS# \_\_\_\_\_ Are you a student? Yes No

Driver's License # \_\_\_\_\_

Home Address \_\_\_\_\_  
Street / Apt # \_\_\_\_\_

Phone Home ( ) \_\_\_\_\_

Work ( ) \_\_\_\_\_

City State Zip

Cell ( ) \_\_\_\_\_

Who Referred you to our office? \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Work phone ( ) \_\_\_\_\_

Nearest Friend/Relative Not Living With You \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Do we have your permission, during the process of providing medical care, to release health information to the above mentioned Spouse Yes or No; or Nearest Friend / Relative Yes or No?

Whom Should We Contact in Case of Emergency? \_\_\_\_\_

**Insurance Information**

Insured's Name \_\_\_\_\_

DOB of Insured: \_\_\_ / \_\_\_ / \_\_\_

(This may not be the patient in some cases, but is the name of the person who has the insurance or is responsible for the bill)

Is this claim related to: Auto Accident? Yes or No  
Work-Injury? Yes or No

if Yes, what was the Date of Injury \_\_\_ / \_\_\_ / \_\_\_  
if Yes, what was the Date of Injury \_\_\_ / \_\_\_ / \_\_\_

Insurance Company Name \_\_\_\_\_

Insurance Phone ( ) \_\_\_\_\_

Address for Claim Submission (see back of card for address)

Policy / Group # \_\_\_\_\_

Claim / ID # \_\_\_\_\_

Work-Comp or Auto Claim Rep Name \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Attorney's Name \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Is this an active and open claim (no litigation pending)? Yes or No

Check the statements you agree with and then sign and date this form at the bottom.

- I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.
- I hereby authorize Mark T. Wheaton, M.D. to examine my (or the patient's) condition as he deems appropriate.
- I hereby assign, authorize, and direct that payment under any insurance policy or health benefits plan be made directly to Mark T. Wheaton, M.D. for any services rendered to me by or on behalf of Mark T. Wheaton, M.D. I also hereby authorize Mark T. Wheaton, M.D. to release to my insurance company, health plan, HMO, no-fault carrier, and/or worker's compensation carrier, any information (including my complete health records) needed to determine benefits for services provided by or on behalf of Mark T. Wheaton, M.D.
- I hereby request and authorize Mark T. Wheaton, M.D. to release medical information about me to my referring physician or the below named location:
- I would like to have a female employee present during my examination / treatment.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## FINANCIAL POLICY

*In our commitment to serving you, we strive to keep you informed of all costs involved in your care. This financial policy outlines our guidelines, please review and sign this agreement before proceeding with treatment. If you have any questions, please ask us to assist you in understanding this policy.*

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Major Medical / HMO / PPO**

Dr. Wheaton is enrolled as a provider in most insurance groups in Minnesota. If he is a provider for your insurance company your office visit charges will be submitted by our billing department. You will NOT be charged for this at the time of service. Each insurance company varies in their payments for our charges. We agree to accept their discounts and their payment for the charges. However, your agreement with your insurance company may require that you pay a certain percentage of the charges (such as a copay, deductible, or a percentage of the services provided). In this case **you agree to be fully responsible for your portion of your bill.**

Pre-authorizations or referrals to be seen or treated at this clinic is your responsibility. You are responsible for knowing what your plan will cover. If you have questions, please contact your insurance company.

In some cases you may be treated with services that are considered “investigational” or “medically unnecessary” by your insurance company, treatments such as prolotherapy. Charges for these services will not be submitted to your insurance company. **Non-covered procedures are charged at the time of service, while covered services will be billed to your insurance company.** This policy/agreement serves as notice that the procedure, prolotherapy, will not be billed to your insurance, unless authorized in writing, in advance of treatment. You will be provided with a treatment estimate prior to treatment which will outline costs, number of treatments, and length of treatments. By signing this agreement, you agree that you have been informed that this is not a covered procedure and that you will be responsible for the full payment at the time of service.

**Worker’s compensation** may cover prolotherapy in some cases, but this must be pre-authorized and presented in writing prior to treatment. We will assist you with this pre-authorization process.

**Auto insurance** companies often cover prolotherapy when your claim is open and active. However, we require full payment at the time of your visit. You will then be given all the necessary paperwork for you to submit these charges to your auto insurance for reimbursement.

### **Copays**

**All copays are due at the time of service.** You may pay these by cash, check or credit card. We accept both VISA and MASTERCARD.

### **No Insurance**

Any patients without current health care coverage will be required to pay their charges in full at the time of service. We do have payment options available through Care Credit, simply ask for an application or apply online at [www.carecredit.com](http://www.carecredit.com). They offer various interest-free plans.

## Medicare

Five years ago Dr Wheaton made the difficult decision of opting-out of the Medicare system. Dr. Wheaton is not currently a Medicare provider (under the Social Security Act), he has again chosen to opt-out of the current two year period of 2006 & 2007. **Therefore, as required by Medicare, all Medicare patients must enter into a private contract with Dr. Wheaton.** You may choose to seek care from a participating physician, or if you do enter a private contract with Dr Wheaton this will not affect your status with other participating Medicare physicians. This contract states that you will be responsible for the full amount of all charges at the time of service, as Medicare will not make payment for any services. Medicare limits may not apply to our charges. As a Medicare beneficiary you agree to not submit any claims to Medicare from our office, or ask us to submit claims as this would be a violation of our agreement with Medicare.

Medicare plans do not, and other supplemental insurance may elect not to make payments for services not paid for by Medicare. Most require that a claim must first be processed by Medicare. Because Dr. Wheaton is not a Medicare provider we cannot submit claims to Medicare, so supplemental insurance often will not pay for these services either.

If services are provided due to an emergency, no private contract with the patient is required.

You will be provided with an estimate of all costs involved in your care with Dr Wheaton

## Payment

Payment may be made by cash, check, VISA, MASTERCARD or Care Credit. If you pay by check and the bank returns your check unpaid, a \$20 fee will be assessed.

Care Credit is a "credit card" for medical expenses. This gives us the ability to offer you several payment options including 3, 6 or 12 month interest-free plans, as well as, 24, 36, and 48 month extended-payment options at a fixed interest rate. If you are interested in this option we will be happy to explain it to you and assist you in applying and using this payment plan, or you can review this option online at [www.carecredit.com](http://www.carecredit.com).

*Your signature indicates that you agree to the above policy and will not allow your account to become delinquent. This agreement applies to all dates of service in this office for up to one year. You may revoke your signature at any time, in writing, but will be held responsible for any bills due prior to the revocation date.*

**Print Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**In summary, all covered services will be submitted to insurance and you will be responsible for your portion of these services based on your agreement with your insurance company. All non-covered services must be paid at the time of service. All Medicare beneficiaries enter into this private contract with Dr Wheaton.**