



WELCOME TO OUR OFFICE

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
AGE: _____ BIRTH DATE: _____ EMAIL: _____
SOCIAL SECURITY: _____

HOME#: _____ CELL#: _____ WORK#: _____
TYPE OF WORK: _____ EMPLOYER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
SPOUSE NAME: _____ SPOUSE'S PH# _____
IN CASE OF EMERGENCY, PLEASE CONTACT: _____ PHONE: _____
PRIMARY CARE PROVIDER: _____ PHONE: _____

Our office will bill your insurance directly for services rendered. Remember that you are ultimately responsible for any charges incurred in this office. **It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not covered by your insurance or other third party payers. Your signature indicates that you agree to pay for any outstanding bills incurred in this office.** I authorize that payment be made directly to Kevin S. Moriarty, D.C. for any and all insurance benefits or reimbursement for services rendered by him. I also authorize the release of any information concerning my health and healthcare services to my insurance companies or other pre-paid healthcare plans. **I understand that there is no guarantee that my insurance companies or pre-paid healthcare plan will cover and pay for all of my charges, and I understand that I am responsible for all remaining charges.**

I hereby give permission to the doctor to administer treatment and perform general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition.

By signing this document, I agree and acknowledge the above statements.

Patient Signature

Date

KEVIN S. MORIARTY, D.C.

Chiropractic 505 W. Hollis St. - Suite 205
Acupuncture Nashua, NH 03062
Massage (603) 595-7434
Sports Medicine www.moriartychiro.com

OFFICE QUESTIONNAIRE

What is your **chief complaint** or primary reason for today's visit?

What are your **expectations or goals** for today's visit or future visits?

Is today's visit related to a **motor vehicle accident or work-related injury**?

How did you first hear about our office, and whom may we thank for **referring** you?

- Internet
- Advertisement
- Friend/Family (name): _____
- Drive by
- Other _____

Name _____ Date: _____

Name: _____

Date: _____

File: _____

PATIENT HISTORY

Please mark the appropriate box and explain your answer if necessary

No Yes

- Headaches _____
- Neck pain _____
- Mid back pain _____
- Rib Pain _____
- Low back pain _____
- Sacroiliac pain _____

- Shoulders _____
- Elbows _____
- Wrists _____
- Hands/Fingers _____
- Hips/Pelvis _____
- Knee's _____
- Ankle's _____
- Feet/Toes _____

- Allergies(Meds/Envtl.) _____
- Dizziness/Vertigo _____
- Ringing in Ears/Tinnitus _____
- Numbness/Tingling _____
- Blurred/Double Vision _____
- Loss of Balance _____

- Eyes/Ears _____
- Nose/Throat _____
- Thyroid _____
- Sinus Condition _____
- Acid Reflux _____
- Gastrointestinal _____
- Nausea _____
- Diabetes _____

No Yes

- Heart Disease _____
- High Blood Pressure _____
- Cholesterol Problems _____
- Gall Bladder _____
- Breathing/Asthma _____
- Skin Disorders _____
- Auto Immune Disorder _____
- Anxiety/Depression _____
- Urinary/Kidney _____
- Prostate _____
- Breast or Uterine _____
- Birth Control Pills _____

- Knocked Unconscious _____
- Concussion _____
- Previous Car Accident _____
- Fractures/Dislocations _____
- Surgeries _____
- Hospitalizations _____

- Smoke _____
- Drink Alcohol _____
- Exercise _____
- Family History _____
- Married _____
- Children _____
- Prev. Chiropractic Care _____
- Other Conditions/Injuries _____
- Cancers _____

COMMENTS:

KEVIN S. MORIARTY, D.C.

Chiropractic
Acupuncture
Massage
Sports Medicine



505 W. Hollis St. - Suite 205
Nashua, NH 03062
(603) 595-7434
www.moriartychiro.com

INSURANCE ASSIGNMENT & PAYMENT AGREEMENT

PATIENT NAME: _____

HEALTH CARE PAYMENT AGREEMENT: As a patient seeking treatment with health insurance,

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I further understand and agree that this assignment, lien and authorization do not constitute any consideration for this office to await payment and will expect payment with accrued interest on any unpaid balance at a rate 1.5% per month. I also understand that I will be charged **\$25.00** for any missed or canceled appointments if 24-hour notification was not given. **By signing this agreement I accept responsibility for unpaid charges to this provider.**

PATIENT SIGNATURE _____ **DATE** _____

MOTOR VEHICLE, WORKER'S COMPENSATION AND PERSONAL INJURY AGREEMENT: (ONLY)

As a patient seeking treatment due to a **Worker's Comp. Claim, Personal Injury or Motor Vehicle Accident, I** authorize and direct that payment be made directly to:

Dr. Kevin S. Moriarty Chiropractic Office
505 West Hollis St Nashua, Suite 205 NH 03062

for any sums as may be due and owing this chiropractic office for services rendered me, both by reason of accident, or illness or any other bills due this office and to withhold such sums from any disability benefits, medical payment benefits, no fault benefits, accident benefits, worker's compensation benefits or any insurance benefits, or from any settlement, judgment or verdict on my behalf. **I also understand I will be charged \$25.00 for any missed or canceled appointments if 24 hour notice was not given.** I further understand and agree that this assignment, lien, and authorization of this office will expect payment with accrued interest on unpaid balances at a rate of 1.5% per month. **This contract is to act as an assignment of my rights and benefits for the office charges and services provided herein.**

PATIENT SIGNATURE _____ **DATE** _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

Date _____

Please read carefully:

Please circle the number that best describes the question being asked.. If you have more than one complaint, for example, neck pain and low back pain, please write the complaint above the number.

1 - What is your pain RIGHT NOW?

No pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2 - What is your TYPICAL or AVERAGE pain?

No pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

4 - What is your pain level AT ITS WORST (How close to "10" does your pain get)?

No pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Mark the areas on this body where you feel the described sensations.

Use the appropriate symbols

Mark areas of radiation

Include affected areas

Numbness	Pins and needles	Burning	Aching	Stabbing
-----	0000000	xxxxxxx	*****	/////////

Pain chart

