Thompson Healthcare
& Sports Medicine
ATLANTIC HEALTH SYSTEM

424 South Main Street, Forked River, NJ 08731
P (609) 971-3500 ~ F (609) 971-3545

General Information

Patient Name:		Social Security #:
Preferred name:		
Sex M / F Other:	Date of Birth:	Age:
Mailing Address:	City: State:	Zip code:
Email Address:	May we contact you via email?: Y / N	May we contact you via text Message?: Y / N
Home Phone #:	Cell Phone #:	Work Phone #:
Employer:	Occupation: Part Time Full Time	
Have you ever been to a Chiropractor ? Y / N	Is Todays Visit related to a Motor Vehicle Accident? Y / N	
Number of Children:	Marital Status: S / M / D / W	
Primary Care Physician:	PCP Phone:	

In Case of Emergency

Contact name:		
Relationship:	Address:	
Home Phone:	Cell Phone:	Work Phone:

How did you hear about our office?
Who may we contact regarding your care/billing? Contact Name: Phone:

Primary Insurance Information

Primary Insurance Company Name:		Subscriber Address:	
ID#:	Group #:	Subscriber Name:	Subscriber SSN:
		Subscriber Phone:	Subscriber Dob:

Secondary Insurance Information

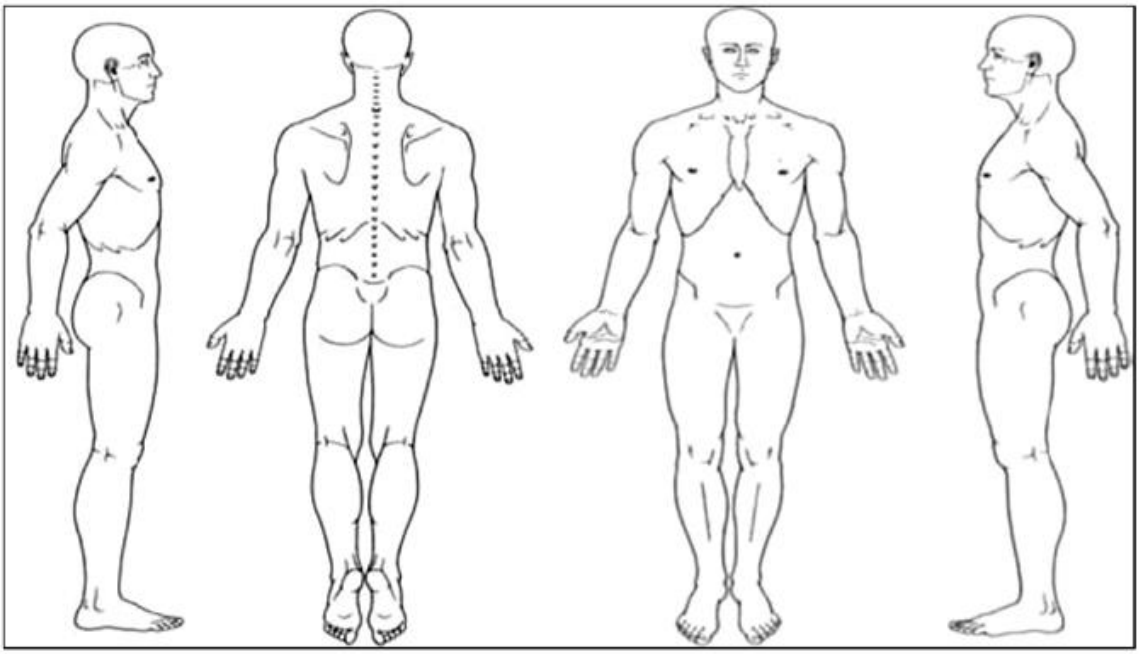
Secondary Insurance Company Name:		Subscriber Address:	
ID#:	Group #:	Subscriber Name:	Subscriber SSN:
		Subscriber Phone:	Subscriber Dob:

Todays Visit

Reason for Today's Visit:			
How long have you had this problem:	YEARS	MONTHS	WEEKS

What makes it better or worse:	Rate the Pain : _____ (0 = nothing, 10 = worst imaginable)

On the diagram below, please indicate where you are experiencing pain right now. Please use key to the right of the diagram to further explain what type of sensations you are experiencing in each area.



A = Ache

B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other

Are you a: (Please circle one) Current Smoker Former Smoker Never Smoked Pipe Smoker Cigar Smoker
If yes, how much did you smoke? 3 cigarettes or less per day ½ a pack per day more than a pack per day Vape Smokers+-

Do you drink alcohol? (Please circle one) YES NO
If yes, How frequently? Socially Only Several times per week Everyday

Do you or have you ever used illicit drugs? (Please circle one) YES NO
If yes, what kind? IV DRUGS PILLS MARIJUANA OTHER

Are you Currently participating in sports? (Please circle one) YES NO
If yes, what sport? GOLF TENNIS FOOTBALL SOCCER BASEBALL BASKETBALL OTHER

Please circle any of the following symptoms that you've experienced recently:			
Constitutional:	Fever	Night sweats	Weight Loss
Eyes:	Red Eyes	Blurred Vision	Vision Loss
Ears / Nose / Mouth:	Nose Bleeds	Sore Throat	Hearing Loss
Cardiovascular:	Chest Pains	Palpitations	Leg Swelling
respiratory:	Shortness of Breath	Chronic Cough	Wheezing
gastrointestinal:	Nausea	Vomiting	Diarrhea
genitourinary:	Burning w/ Urination	Blood in Urine	Urinary Inconsistency
skin:	Rash	Hives	Skin Infection
neurological:	Headache	Tremor	Seizures
psychiatric:	Depression	Panic Attacks	Suicidal Ideation
endocrine:	excessive Thirst	Cold Intolerance	Excessive Sweating
hematological:	Easy Bruising	Swollen Glands	Easy Bleeding
allergy / immune:	Runny Nose	Sinus Congestion	Itchy Eyes

Past Medical History (Please circle one)

High Blood Pressure	Coronary Artery Disease	Vascular Disease	Emphysema
Diabetes	Congestive Heart Failure	Heart Disease / Attack	Thyroid Disease
Lyme's Disease	Bleeding Disorder	Seizures	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteoarthritis	Rheumatoid Arthritis	Stomach Ulcers	Kidney Disease
Asthma	COPD	Cancer	Scoliosis
Depression	Other:		

Family History (Please circle one)

Bleeding Disorder	Coronary Artery Disease	Hepatitis	Cancer
heart Disease / Attacks	Seizures	Lung Disease	Rheumatoid Arthritis
Kidney Disease	Malignant Hyperthermia	Scoliosis	Asthma
Other:			

Surgical History (Please Circle one)

SURGERY	DATE	SURGERY	DATE
Knee Arthroscopy (right / Left)		Shoulder Arthroscopy (right / Left)	
Spine Surgery		Joint Replacement Surgery	
Hernia Repair		Laparotomy	
Eye Surgery		Thyroid Surgery	
Peripheral Bypass Surgery		Cardiac Catheterization	
Coronary Artery Bypass Surgery		Hysterectomy	
Pacemaker		defibrillator	

Please list any other surgery you may have had in the past not previously mentioned:

_____

_____

_____

Please list any Medications you are on, or have taken in the past 6 months:

_____

_____

_____

Please list anything you may have an allergic reaction from:

_____

_____

_____

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Reviewed By Physician: _____ Date: _____

Thompson Healthcare & Sports Medicine

FINANCIAL POLICY AGREEMENT / ASSIGNMENT OF BENEFITS

Thank you for choosing **Thompson Healthcare & Sports Medicine** as your healthcare provider. We are committed to providing excellent care and assisting you in understanding your financial responsibilities.

Insurance Participation

We participate with many insurance plans, including Medicare and select commercial carriers. As a courtesy, we will verify benefits and submit claims on your behalf. Coverage varies by plan, and it is your responsibility to understand your copayments, deductibles, coinsurance, and non-covered services.

In-Network Services

If we are in-network with your plan:

- Copayments, deductibles, and coinsurance are due at the time of service
- Any remaining balance after insurance processing is your responsibility

Out-of-Network Services

If we are not participating with your plan:

- Claims will be submitted on your behalf unless otherwise requested
- You may be responsible for out-of-network cost-sharing and any difference between billed charges and allowed amounts, if applicable
- If payment is sent directly to you, you agree to remit it to Thompson Healthcare & Sports Medicine within 30 days.

Treatment recommendations are based on medical necessity and are not limited by insurance determinations.

New Jersey Patient Protections

Under New Jersey law, patients receiving inadvertent out-of-network services at an in-network facility are protected from balance billing beyond in-network cost-sharing. You will be responsible only for applicable in-network amounts in these situations. You will be informed of your rights when applicable.

Patient Financial Responsibility

Payment is expected at the time of service for all known balances. Any remaining balance after insurance processing is your responsibility. Unpaid balances may be subject to collections in accordance with applicable laws.

ASSIGNMENT OF BENEFITS

I irrevocably assign all insurance benefits to Thompson Healthcare & Sports Medicine for services rendered. I authorize the release of necessary information for claim processing and direct that all payments be made to the practice. I authorize the practice to file claims on my behalf and act on my behalf regarding insurance matters as permitted by law.

I acknowledge that I have read, understand, and agree to this financial policy.

Patient Name: _____ **Date:** _____

Signature: _____