Patient Intake Form

For Office Use Only
Chart #:________________
Patient Height___________
Patient Weight__________
Respiration ____________
Patient Blood Pressure _______
Pulse______________________
Temperature _______________

Name: ____

DOB: ____

Date: ____

Employer: ____________________________Occupation: ____

Primary Care Physician: __________________________________

Are your present problems due to an injury? ❑Yes ❑No **(If answer is no, move to next section and complete form)**

Enter the date of the injury:______________________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other:

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other

List symptoms experienced immediately after the injury: Choose the severity associated with the symptom

_________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Were you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ____________________ Transported by? ❑Ambulance ❑Police ❑Other

Date Admitted: ______________ Date Released: ______________ Length of Stay: ______________

Briefly describe the injury or condition (s) and when you first noticed: ____

____

List any tests, studies or medications received for this condition:

❑Tests/Studies:____

❑Medications:____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No

____

Do you have any current work restrictions due to this condition? ❑Yes ❑No ____

Off work:❑Yes ❑No ❑Previously From: __________ To: __________ Light duty: ❑Yes ❑No

❑Previously (If yes, what are/were your restrictions? ____

Chart# _____

HABITS

❑Smoking Packs/day: _____
❑Drinking Alcohol: (Times/WK): ____
❑Coffee Cups/Day: _____
❑Soft Drink Cans/Day: _____
❑Water Cups/Day: _____

EXERCISE

❑None
❑Light
❑Moderate
❑Heavy

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑_____
Father	❑	❑	❑	❑_____
Brother(s)	❑	❑	❑	❑_____
Sister(s)	❑	❑	❑	❑_____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc?
❑Yes ❑No If yes, which ones? _____
_____

Have you ever had any surgeries? ❑Yes ❑No (If yes, enter type and approximate date of surgery.) _____
_____

Is there any possibility you are pregnant? ❑Yes ❑No
Have you ever had X-rays or imaging performed? ❑Yes ❑No When? _____Reason?_____

OPERATIONS AND PROCEDURES

What other symptoms or conditions have you experienced?

GENERAL SYMPTOMS

❑ Allergy(What) ____
_____
❑ Bronchitis
❑ Chills(Constant)
❑ Convulsions
❑ Dizziness
❑ Fainting
❑ Fatigue
❑ Headache
❑ Loss of Sleep
❑ Loss of Weight
❑ Nervousness
❑ Night Sweats
❑ Numbness or Pain in arms/legs/hands
❑ Wheezing

GASTRO-INTESTINAL

❑ Belching or Gas
❑ Colon Trouble
❑ Constipation
❑ Diarrhea
❑ Gall Bladder Trouble
❑ Hemorrhoids (piles)
❑ Jaundice
❑ Liver Trouble
❑ Nausea
❑ Stomach Pain
❑ Vomiting
❑ Heart Burn
❑ Bloody Stools
❑ Acid Reflux
❑ Irritable Bowel

EYE/EAR NOSE/THROAT

❑ Asthma
❑ Deafness
❑ Earache
❑ Ear Discharge
❑ Ear Noises
❑ Thyroid Problems
❑ Frequent Colds
❑ Hay Fever
❑ Nasal Obstruction
❑ Nose Bleeds
❑ Pain in Eyes
❑ Poor Vision
❑ Blurred Vision
❑ Sinusitis
❑ Sore Throats
❑ Tonsillitis

RESPIRATORY

❑ Chest Pain
❑ Chronic Cough
❑ Difficulty Breathing
❑ Spitting Blood
❑ Spitting Phlegm

GENITO-URINARY

❑ Bed Wetting
❑ Blood in Urine
❑ Frequent Urination
❑ Poor Bladder Control
❑ Kidney Infection
❑ Kidney Stones
❑ Painful Urination
❑ Prostate Trouble

Chart# _____

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer		

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT **CHART #_____**

TO: WAKE FOREST CHIROPRACTIC

In consideration of your rendering care to me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

_____ **I DO NOT** authorize Wake Forest Chiropractic, PA to release any information concerning my medical care to ***any*** individual.

_____ **I DO** authorize Wake Forest Chiropractic, PA to release any information concerning my medical care and/or financial matters to the additional individual(s) listed below:

Name:_____ Phone#: _____

Name:_____ Phone#: _____

_____ **I DO** authorize Wake Forest Chiropractic, PA to contact me by options listed below **(check all boxes that apply)**:

□ phone (cell/wk/hm) □ email confirming appointments only □ email to include any/all appointments, any/all patient information including statements (If requesting records and/or statements, although encrypted, any online correspondence may come with a certain amount of risk) □ text messages to include leaving a detailed phone message, confirming any/all appointments or a message pertaining to a medical issue.

_____ **I DO NOT** authorize Wake Forest Chiropractic, PA to leave a message concerning appointments or medical issues or to email my patient information/statements.

ASSIGNMENT OF BENEFITS

The undersigned hereby assigns to **Wake Forest Chiropractic** all right, title and interest in and to any compensation or payment in any form that the undersigned received or shall receive as a result of or arising out of the treatment of the patient.

The undersigned hereby authorizes and directs any person or corporation having notice of this assignment to pay **Wake Forest Chiropractic** directly the amount of the indebtedness owed to **Wake Forest Chiropractic** in connection with services rendered to the patient.

This assignment is made without prejudice to any rights that the patient, and the undersigned might have to compensation for injuries incurred by the patient, but the undersigned hereby authorizes and directs any person or corporation having notice of this assignment to pay to **Wake Forest Chiropractic** directly the amount of the indebtedness owed to **Wake Forest Chiropractic** in connection with services rendered to the patient. I also agree to pay **Wake Forest Chiropractic** the full amount of my charges, should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claims.

Patient Signature (or guardian): _____ Date: _____

Print Patient Name: _____Patient Date of Birth: _____

Witness: _____

OFFICE POLICIES/FINANCE AGREEMENT CHART # _____

We are honored that you have chosen us for your healthcare needs and we are committed to the successful management of your condition. This will require diagnostic procedures that may include x-rays and a treatment phase that may include physiotherapy. Additionally, today's health care system requires that we reach a clear understanding to meet your needs effectively and prevent confusion.

- ✓ **We will verify your benefits, file and track your insurance payments as contracted.**
- ✓ **You are responsible for the full payment of any fees the insurance company will not cover or remain as a result of incorrect verification information received by our office.**
- ✓ **Appointments are scheduled to give optimal time and individual attention. If you need to reschedule an appointment, please give 24 hours notice. If you do not, you will impact another patient's ability to be seen during that time and may be charged a $25 missed appointment fee.**
- ✓ **Patients that develop a pattern of missed appointments are released from care and referred to another provider who may be better suited to meet the patient's schedule and needs.**
- ✓ **For your protection, all x-rays produced in our office are sent for review by a Board Certified Chiropractic Radiologist. There is only one radiologist of this specialty in our area. The radiologist does not accept insurance assignment so there will be a nominal fee for their service.**
- ✓ **With regard to x-rays; patients or insurance companies pay for the technical service and professional interpretation of the x-rays, *but do not own the films themselves*. This is because physicians are required to keep the films on file for 7 years. We will be happy to provide you with a copy of your x-rays for another provider to review, however we do require a forty-eight (48) hour notice for this process.**

INSURANCE/THIRD PARTY COVERAGE

We will supply you with information regarding deductibles, co-payments, covered charges, secondary insurance and usual and customary charges, but keep in mind that your carrier will state; "the stated benefits are not a guarantee of payment". We accept and file group health insurance, Workers' Compensation, managed care plans, Medicare, and automobile liability insurance. However, services rendered are the ultimate responsibility of the patient receiving care.

FLEX CARDS/HSA CARDS

It is possible to pay for co-pays, coinsurance, supplies and/or nutritional supplements with your insurance Flex or HSA cards. However, if they deny these charges, it will be your responsibility to reimburse the administrator of this card, not the responsibility of Wake Forest Chiropractic.

OTHER FORMS OF PAYMENT

Patients that do not have insurance or third party coverage are responsible for full payment at the time of service. We accept cash, personal checks, VISA and MasterCard. Please have any credit arrangements authorized in advance.

SPECIAL ARRANGEMENTS

We have never denied anyone the benefits of chiropractic care because of his or her inability to pay for care. If financial hardship exists, special arrangements for payment will be made.

BILLING

Some of Dr. Phelan's most gratifying days in practice are when he has provided services voluntarily during toy and food drives and in third world countries. However, if we are providing services under financial arrangements there have to be parameters. The following is a description of the management of outstanding balances that ***we would prefer never*** to follow, but do when the need arises. Please be aware of this process.

Outstanding balances are billed monthly and considered past due 30 days after the invoice date. Balances older than 90 days will accrue interest charges of 1.5% per month plus any legal or collection fees or if a credit card is required to secure care you will be notified that the credit card will be billed. Accounts may be turned over to collections with a 30% fee after notification. Returned checks are subject to a $25 fee.

CREDIT CARD PAYMENTS ON FILE

_____(Initial) I authorize you to charge my balance directly to my credit card(s) on file. Since the payment amount may vary, I will be notified in person or by phone/answer machine to inform me of the amount being charged. The authorization is valid until I provide you with a written cancellation.

PATIENT AGREEMENT

I have read and understood this agreement, as well as the Notice of Privacy Practices (HIPPA).

_____ _____

Signature of Patient/Responsible Party **Date**