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 ONLY	CARDIO-VASCULAR	SKIN OR ALLERGIES	FOR FEMALES
❑ Backache	❑ High Blood Pressure	❑ Bruising Easily	❑ Cramps
❑ Foot Trouble	❑ Low Blood Pressure	❑ Dryness	❑ Hot Flashes
❑ Hernia	❑ Chest Pain	❑ Eczema	❑ Irregular Cycle
❑ Pain Between Shoulders	❑ Heart Trouble	❑ Hives or Allergy	❑ Painful Periods
❑ Painful Tail Bone	❑ Poor Circulation	❑ Itching	
❑ Stiff Neck	❑ Rapid Heart	❑ Sensitive Skin	
❑ Spinal Curvature	❑ Slow Heart	❑ Skin Eruptions	
❑ Swollen Joints	❑ Strokes		
❑ Tremors	❑ Swelling Ankles		
	❑ Varicose Veins		

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 and/or financial matters 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:

□ phone (cell/wk/hm) □ email □text 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.

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 of your insurance provided by your carrier. If you disagree with the processing of our services by your insurance carrier, it is your responsibility to dispute this with the carrier.**
- ✓ **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.**

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". Some carriers will combine chiropractic benefits with physical therapy and it is up to the patient to confirm and monitor. **If your claim doesn't process as per benefits quoted, we will notify you as soon as we are made aware. In this rare instance, you may end up with a balance and if this is the case, your credit card of record will be charged. It would be in your best interest to stay on top of your explanation of benefits from your insurance carrier from each appointment, making sure they are paying as expected.**

_____ Initials _____Tracer#

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. ***It is your responsibility as the patient to keep us up to date on any changes to your insurance carrier and/or if a deductible or maximum allowed visits have been met.***

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

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.

- Health Insurance 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. 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.
- Liability cases are considered past due after 1 year from the initial visit. The account will accrue interest charges of 1.5% per month plus any legal or collection fees. 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. _____ **Initial**

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 understand that if I end up with a balance and I will be charged. 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**

Wake Forest Chiropractic

Informed Consent to Chiropractic Treatment

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. Although the documented history of risks with chiropractic treatment shows that it is very safe, particularly when compared to other types of health care; in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include muscular soreness, sprain/strain injury, disc herniation and fractures. One of the rarest complications associated with chiropractic care, which has been estimated to occur at a rate between one instance per one million to one in ten million cervical spine (neck) adjustments; may be a vertebral artery injury that could lead to stroke.[1] Dr. Wagoner takes every precaution to reduce risks during treatment.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, overall health and the health of your spine. These procedures will assist us in determining if chiropractic care is needed, or if further examinations, studies or specialist referrals are required. All relevant findings will be reported to you along with a treatment plan prior to beginning care.

Your health also depends on your active participation. We will make a number of recommendations to help improve your health and functional status, such as home care, a treatment schedule and exercises or other activities that have been shown to help conditions such as yours. We draw attention to this at this time to help you understand your responsibility to follow these recommendations in order to meet your recovery goals.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations the doctor deems necessary and to the chiropractic care, including spinal manipulation (adjustment), as reported following my assessment. I have been given the opportunity to ask questions regarding potential risks prior to beginning care.

_____ _____

Patient or Legal Guardian Signature Date

Eric J. Wagoner, DC

_____ _____

Witness Signature (office staff) Date

1. Cassidy D, et. al (2008). Risk of Vertebrobasilar Stroke and Chiropractic Care: Results of a Population-Based Case-Control and Case-Crossover. Spine, Volume 33, Number 4S, pp S176–S183.