NEW PATIENT INTAKE FORM

Date _____ Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ SS# _____

Age _____ Date of Birth _____ Sex: M F Occupation _____

Employer _____ Work #_____

Address _____City_____ State_____

Marital Status S M W D Number of Children _____ Email: _____

Spouse's Name _____ Cell Phone _____

Spouse's Employer _____City_____ State_____ Work #_____

EMERGENCY CONTACT INFORMATION: Please give name and number of 2 nearest relatives or friends:

_____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

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

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
No. of__ Sister	☐	☐	☐	☐	☐
No. of__					

TO THE PATIENT: Please list below the five or more main complaints you have in the order of importance. Also the length of time you have had this complaint.

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____
5. _____ How long? _____

List other doctors seen for this condition, their diagnosis and treatment _____

_____

List surgical operations and years: _____

_____

Any recent injuries, falls or accidents? _____

_____

How did you find out about our office? _____

Date of last visit _____ Have you been to chiropractor before? Y N

Will we be processing insurance for you? Y N Type: ___ Personal ___ Medicare ___ Auto ___ Other

PLEASE LIST ALL INSURANCE(S) – BOTH IN AND OUT OF NETWORK:

_____

_____

Please check the type of care desired so that we may be guided by your wishes when possible:

___ Temporary Relief ___ Control of Immediate Pain ___ Total Health Care ___ Doctor select the type of care for me

"I understand and agree that the above information is correct as stated."

Patient's Signature _____

Date _____ Parent or Guardian Signature (if minor) _____

RESPONSIBLE PARTY FOR THIS ACCOUNT:

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____ SS# _____

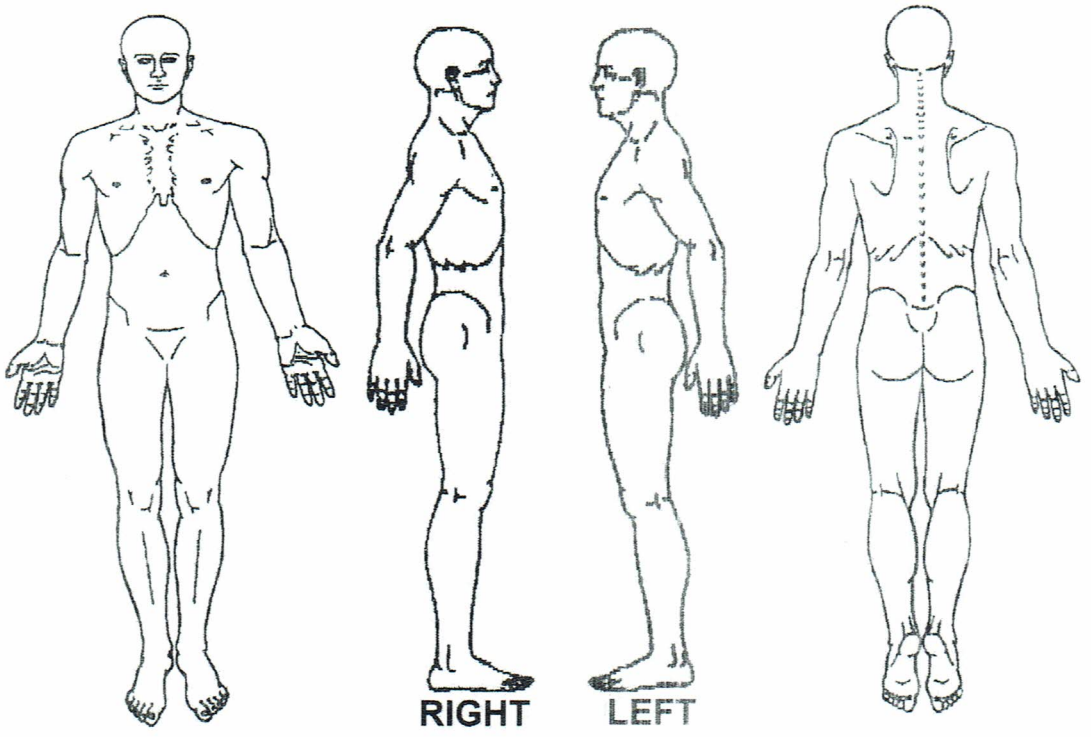
Employer _____ Work # _____

Work Address _____ City _____ State _____ Zip _____

PATIENT CONSULTATION

Name: _____ Date: _____

AREAS OF COMPLAINT:



Please list prescription medications you are taking: _____

_____

Patient's Signature _____

OFFICE USE ONLY BELOW LINE

Ht _____ **Wt** _____ **BP** _____ **Pulse** _____ **Temp** _____

Comments:

_____

_____

_____

_____

_____

Doctor's Comments:

_____

_____

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

Please list the names of any family/friends who have permission to receive information concerning you and/or your PHI from our staff. You maintain the right to rescind permission at any point.

Name	Relationship
Name	Relationship
Name	Relationship

By subscribing my name below, I acknowledge receipt of a copy of this Privacy Notice, and my understanding and my agreement to its terms.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

Staff Initials: _____

WELCOME TO OUR OFFICE...

We appreciate the opportunity to be a part of your health care team. Here at our office we do an initial 3 visit plan of treatment, and you will be treated on each visit unless there are extenuating circumstances. We are required by law to do a complete orthopedic exam on new patients and this is broken down over your first 2 visits in order to prevent exacerbation of an aggravated condition. Although the exam spans the first 2 visits, the cost is one fee and is paid on the initial visit. On your third visit, we do a Report of Findings where we will review with you your test results and x-rays. There is no charge for the Report of Findings, but we are anticipating treating you on that day and you will be billed for the treatment. At that time you will be aware of what your condition is and you can select the level of care you would like, whether it be relief care or corrective care.

We also let our new patients know that if you return for a second treatment ON THE SAME DAY, there is no additional charge for that treatment.

Once again, thank you for the opportunity to be a part of your health care team.

The Staff of Rushin Chiropractic Center

Patient Initials _____ Date _____