Welcome to Four Rivers Chiropractic

Patient Intake Form

Patient Information

Name:_____Date:_____
First MI Last

What do you prefer to be called?_____

Address:_____City:_____State:_____ Zip:_____

Home Phone #:_____ May we leave a message at this number? Yes ☐ No ☐

Work Phone#:_____ May we leave a message at this number? Yes ☐ No ☐

Cell Phone #:_____May we leave a message at this number? Yes ☐ No ☐

E-mail Address:_____ Opt out of e-mail ☐

Gender: Female ☐ Male ☐ Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Date of Birth:_____ Social Security Number:_____

How did you hear about our office or who referred you?_____

Employment Status: Employed ☐ Unemployed ☐ Retired ☐ Student ☐

Employer:_____Occupation:_____

Business Address:_____City/State/Zip:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone Number:_____

Would you like to allow your emergency contact access to your personal health information?

Yes ☐ No ☐

Payment Information **(must be completed for all patients less than 18 years of age)**

Person Responsible for Payment:_____ Relationship to Patient:_____

Address:_____City:_____State:_____ Zip:_____

Social Security Number:_____ Phone:_____ Date of Birth:_____

Insurance Information

Do you have health insurance? Yes ☐ No ☐	
Primary Insurance Information below is same as responsible party ☐	**Secondary Insurance** Information below is same as responsible party ☐
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Address:	Policy Holder's Birth Date:
City/State/Zip of Policy Holder:	Policy Holder's Address:
Policy Holder's Date of Birth:	City/State/Zip of Policy Holder:
Policy Holder's Phone Number:	Policy Holder's Phone Number:
Please be sure to give all insurance cards and your driver's license to the office staff so they can be copied for our records.	

Consent to Release Health Information & Notice of Privacy Policy

By signing below, I authorize Four Rivers Chiropractic to release personal health information (PHI) required by my insurance company(s) or to any individual listed below. Our practice defines PHI as any information that is protected under the HIPPA Privacy Rule. It includes, but is not limited to, all appointment information, lab/test results, etc. I authorize my insurance company(s) to pay benefits directly to Four Rivers Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. ***I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor.*** *I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations including but not limited to my insurance company, primary care physician, other requesting physician, legal representative, and those individuals I have listed below.*

Privacy Policy – I realize that I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties_____(patient initials)

Contact Release Information- I agree to permit Four Rivers Chiropractic and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile device concerning any and all aspects of my account: financial, procedural or scheduling. I also give permission to be sent occasional cards, letters, emails, or health information as an extension of my care in this office_____(patient initials)

By signing below, I give my consent for examination and the performance of any tests or procedures needed as well as the release of PHI to insurance companies and the individuals listed below. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Patient Signature: _____Date: _____

Authorization to release Personal Health Information to the following individuals:

Name:_____Relationship:_____ Phone Number:_____

Name:_____Relationship:_____ Phone Number:_____

Health Questionnaire

Patient Information

Patient Name:_____

What is the reason for your visit today?_____

Is this the result of a Work Comp Injury? Yes ☐ No ☐
Is this the result of Motor Vehicle Accident? Yes ☐ No ☐
Is this the result of a Liability Accident? Yes ☐ No ☐

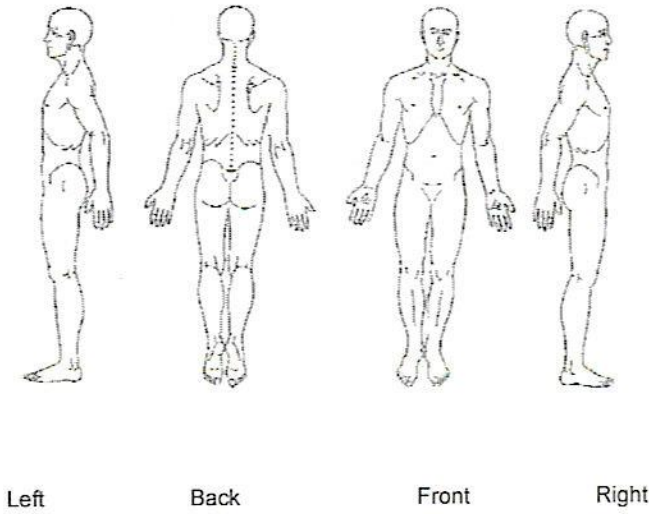
<u>If you answered "Yes" to any of the above please see the receptionist immediately.</u>

Description of Symptoms

How long ago did you first notice the symptoms?_____

Is the condition getting progressively worse? Yes ☐ No ☐

Please mark any areas of discomfort with an X:



Are any of the following activities difficult to perform due to pain or make your pain worse?
Sitting ☐ Walking ☐ Standing ☐ Bending ☐ Lying down ☐ Lifting ☐ Coughing ☐
Sneezing ☐ Bowel Movement ☐ Looking Up ☐ Looking Down ☐ Turning Head ☐ Other ☐_____

Do any of the following describe the type of pain you are experiencing?
Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐
Stiffness ☐ Swelling ☐ Other ☐_____

On a scale of one to ten how intense are your symptoms? (place an X on a number)
Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

Past Medical History

Primary care physician: _____ Phone Number: _____

Date last seen:_____ Have you seen a chiropractor before? Yes ☐ No ☐

Please list any known drug allergies:_____

Please list any other known allergies:_____

(women) Are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

Are you using birth control? Yes ☐ No ☐ Are you currently trying to become pregnant? Yes ☐ No ☐

How often do you experience the symptoms for which you are seeking treatment today?

Constantly ☐ Occasionally ☐ Frequently ☐ Intermittently ☐

Do your symptoms interfere with any aspect of your work or normal activities? If so, please describe:_____

_____

Please indicate if you are currently experiencing any of these conditions or have had them in the past:

Condition	Past	Currently	Condition	Past	Currently	Condition	Past	Currently
Abdominal pain	○	○	Elbow/ upper arm pain	○	○	Knee/ lower Leg pain	○	○
Abnormal weight loss/gain (circle one)	○	○	Epilepsy	○	○	Liver/gall bladder Disorder	○	○
Allergies	○	○	Excessive thirst	○	○	Loss of bladder Control	○	○
Angina	○	○	Frequent Urination	○	○	Low back pain	○	○
Ankle/foot pain	○	○	General Fatigue	○	○	Mid back pain	○	○
Arthritis	○	○	Hand pain	○	○	Neck pain	○	○
Asthma	○	○	Headache	○	○	Painful urination	○	○
Bladder infection	○	○	Heart attack	○	○	Prostate problems	○	○
Birth control	○	○	Hepatitis	○	○	Psoriasis	○	○
Cancer	○	○	High blood pressure	○	○	Shoulder Pain	○	○
Chest pain	○	○	Hip/upper leg pain	○	○	Tobacco Use	○	○
Chronic sinusitis	○	○	HIV/AIDS	○	○	Stroke	○	○
Depression	○	○	Hormone Therapy	○	○	Thoracic Outlet	○	○
Dermatitis/Exzema	○	○	Jaw Pain	○	○	Ulcer	○	○
Dizziness	○	○	Joint swelling/ stiffness	○	○	Upper back pain	○	○
Drug/ alcohol use	○	○	Kidney Stones	○	○	Wrist pain	○	○

History of Treatment

What treatment have you already received?

Medication ☐ Surgery ☐ Physical Therapy ☐ Other ☐_____

Please list names and type of doctors you have already seen for this condition:_____

_____

Have you had x-rays taken? Yes ☐ No ☐ When?_____ Where?_____

Daily Habits

Tobacco Use: Never ☐ Former ☐ (Quit Date:_____) Current ☐ (# of cigarettes/day_____)

Water Consumption: Never ☐ Yes ☐ _____drinks per day/week (circle one)

Coffee or Caffeinated Beverage Use: Never ☐ Yes ☐ _____ drinks per day/week (circle one)

Alcohol Use: Never ☐ Yes ☐_____ drinks per day/week (circle one)

Recreational Drug Use: Never ☐ Not Currently ☐ Yes ☐ (please specify_____)

Amount of exercise performed on a daily basis? None ☐ Light ☐ Moderate ☐ Heavy ☐

What do your daily work habits include? Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐

Do you take a daily vitamin? No ☐ Yes ☐ (what kind or brand_____)

Are you interested in talking with Dr. Gould about weight loss? Yes ☐ No ☐

Past Surgical History

Please list any past surgeries and the date they were performed

Date:_____Procedure:_____

Date:_____Procedure:_____

Date:_____Procedure:_____

Family Medical History

Please list any conditions the following family members currently suffer from or have suffered from in the past. (ex: Diabetes, Cancer, Heart Disease, Hypertension, MS, Lupus, Chronic Back/Neck Pain etc…)

Father:_____

Mother:_____

Siblings:_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge and that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.

Patient Signature_____ **Date:**_____

17 years of age and under requires the signature of a Parent / Legal Guardian / Responsible Party

Financial Policy, Patient Bill of Rights and Responsibilities

Thank you for choosing Four Rivers as your Healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As part of our professional relationship, it is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services. It is your responsibility to provide us with your most current insurance information.

1) If you do not have health insurance, or your health insurance does not have chiropractic benefits, you are financially responsible for the full amount of services rendered.

2) We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

3) If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for the full amount of services rendered.

4) <u>Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.</u>

5) Before receiving services, you should verify that we are a participating provider in your insurance plan. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your primary care provider listed on your insurance card before you are seen by another healthcare provider.

6) Co-payments must be collected at the time of service. This is a requirement set by your insurance company. No exceptions.

7) You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.

8) Billing and/or finance fees will be added to any patient balance greater than 30 days past due.

9) Personal injury or automobile accident cases: It is our office policy to allow 90 days after you have been dismissed from care for the claim to be settled with the liability company. Once the 90 days has lapsed, if no settlement has been made on the account, we require the patient to begin making payments toward their personal injury case.

By signing below you acknowledge that you have read the above document and fully understand its terms.

Print Patient Name:_____ Date:_____

Patient Signature:_____ Date:_____