

SUCHEY CHIROPRACTIC, PLLC

Electronic Health Records Intake Form

Name: _____ Sex : M F D.O.B. ____/____/____

Phone Number: _____ Height: _____ Weight: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Social Security # ____/____/____ Driver's License # _____

Status: Single Married Divorced Widowed Smoking Status: Presently Past Never

E-Mail Address: _____@_____

Employer: _____ Occupation: _____

Work Phone: _____ May we contact you at work? YES NO

Emergency Contact: _____ Phone Number: _____

Name of Insurance 1. _____ 2. _____

Insured's Name _____ Insured's D.O.B. ____/____/____

Patient Relationship to Insured: Self ____ Spouse ____ Dependent ____ Other ____

*Female Patients: To your knowledge, are you pregnant at this time? Yes or No

Table with 5 columns: Diagnosis (Write in below), Father, Mother, Sibling: (), Offspring: (). Includes an example row for Heart Disease.

Table with 2 columns: Medication Name, Dosage and Frequency (i.e. 5mg once a day, etc.).

Table with 4 columns: Medication Name, Reaction, Onset Date, Additional Comments.

Primary Care Physician: _____ Phone Number: _____

SUCHEY CHIROPRACTIC, PLLC

Patient Name: _____ **D.O.B.** ____/____/____

Briefly describe your chief complaint (symptoms): _____

Start Date? _____ **Is this your first episode of pain in this area?** **Y** **N**

Any falls, accidents, or injuries? If yes, please list: _____

Have you received treatment for your symptom(s): _____

What makes the symptoms better? _____ **Worse?** _____

Please list any surgeries: _____

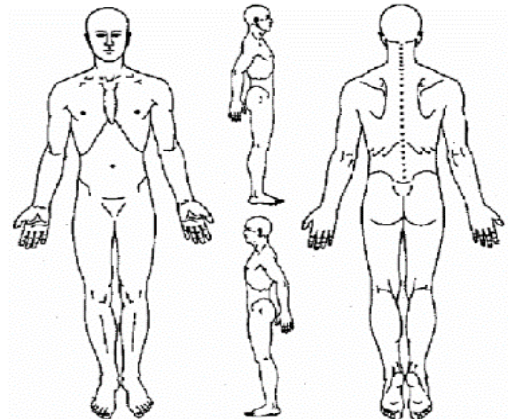
Please indicate the average intensity of your symptoms 1 (Mild) to 10 (Unbearable):

____ Neck ____ Middle Back ____ Lower Back ____ Headaches ____ Arm & Hand
 ____ Legs ____ Shoulders ____ Ribs ____ Hip Joints ____ Feet

Please circle any current symptoms and past problems:

- | | | | | |
|--------------------------------------|--------------------------------------|--------------------------------|----------------------------------|---------------------------------|
| Arthritis | Loss of Balance/
Dizziness | Neck Pain/ Grating
in Neck | Tuberculosis (TB) | Pinched Nerves in
Back |
| Painful Joints/
Swollen Joints | Cold Sweats | Tight Shoulders | Pins & Needles in
Arms/Hands | Disc Problems |
| Rheumatic Fever | Fatigue/ Sleeping
Problems | Thyroid Trouble | Cold Hands/ Cold Feet | Sexual Dysfunction |
| Headaches/
Shooting Head
Pains | Stress/Nerves | Chest Pains/ Heart
Problems | Gall Bladder | Pains in Feet and/or
legs |
| Lights Bother Eyes | Loss of
Memory/Ringing
in Ears | High or Low Blood
Pressure | Mid Back Pain/ Low
Back Pain | Cancer |
| Twitching of Face | Loss of Taste | Anemia | Liver Trouble | Stomach Trouble/
Indigestion |
| Strokes | Sinus Trouble/
Allergies | Shortness of
Breath/ Asthma | Kidney and/or Bladder
Trouble | Diabetes |
| | | | Constipation/Diarrhea | |

Please indicate the location of your chief complaint by circling below:



SUCHEY CHIROPRACTIC, PLLC

Who is responsible for your bill?

You and: Personal Insurance Medicare Workers Comp Auto

In order to receive the best care possible within your benefits, it is important that you comply with our financial policy:

1. Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment.
*It is illegal to waive these fees.
2. Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office.
 - I understand that I am responsible for my bill.
 - I authorize use of this form on all my insurance submissions.
 - I authorize release of information to all my insurance companies.
 - I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
 - I authorize direct payment to my doctor.
 - I authorize the release of information to the following individuals (Ex: Spouse, Children, other Family Members):

* _____ * _____ * _____ * _____

"I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all payments for services rendered to me or my dependents."

Suchey Chiropractic HMO/PPO Limitation of Liability

Your insurance plan may have limitation for services covered in our office. According to your specific plan, the following services may not be covered:

- **Examinations, Re-examinations, Diagnostic Tests, Massage Therapy, Vitamins, Supplements, or Supports, and Modalities (Such as EMS, Ultrasound, Hot/Cold Packs).**

Should any of these determinations be made by your plan, you agree that you have been informed before the services were rendered and you agree to be responsible for payment of the specific services listed above.

Consent to Treat and Notice of Privacy Practices

My signature stands as proof that I give Suchey Chiropractic my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice (If you would like to obtain a copy of this notice, please feel free to ask the front desk).

Clinical Summary

I agree to waive my clinical summary after each visit, as these summaries are often repetitive as a nature and frequency of chiropractic care (If you would like to obtain a clinical summary, please feel free to ask the front desk).

Xrays

I understand that any Xrays taken will remain property of Suchey Chiropractic, and I will have the ability to check them out on loan if necessary.

Patient Name (Printed) _____ DOB ____ / ____ / ____

X Patient/ Guardian Signature _____ Date ____ / ____ / ____

X Authorized Representative Signature _____ Date ____ / ____ / ____