Electronic Health Records Intake Form

Name: ____ **D.O.B.** ____/____/____ **Sex :** □ M □ F

Phone Number: _____________________________ **E-Mail:**________________@___________________

Mailing Address: ____

City: ____ **State:** _____________ **Zip:**___________________

Social Security # ______/______/_______ **Status:** □ Single □ Married □ Divorced □ Widowed

Emergency Contact: __________________________ **Phone Number:** _____________________________

Employer: ________________________________ **Occupation:** _________________________________

Work Phone: ____________________________ **May we contact you at work?** □ **YES** □ **NO**

Do you currently have insurance? **YES** **NO**

Provider:_______________________**Contract#:**_______________________**Group#:**________________

Relationship to insured: ***Self*** ***Spouse*** ***Dependent*** *(Please provide copy of insurance cards)*

Policy Holders Name (if different from patient): __________________________**D.O.B.** ____/____/____

Medical History:

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (____________)	Offspring: (____________)
Example: Heart Disease				

Smoking Status: □ Presently □ Past □ Never **Height:** ________ **Weight:** ________

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

Primary Care Physician: __________________________ **Phone Number:** _____________________

Describe your chief complaint (symptoms): ____

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

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

Have you received treatment for your symptom(s) Y N If yes, when?_________________________

What makes the symptoms better? _____________________ **Worse?**____________________________

Please list any surgeries: ____

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

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

Painful Joints/ Swollen Joints

Rheumatic Fever

Headaches/ Shooting Head Pains

Lights Bother Eyes

Twitching of Face

Strokes

Loss of Balance/ Dizziness

Cold Sweats

Fatigue/ Sleeping Problems

Stress/Nerves

Loss of Memory/Ringing in Ears

Loss of Taste

Sinus Trouble/ Allergies

Neck Pain/ Grating in Neck

Tight Shoulders

Thyroid Trouble

Chest Pains/ Heart Problems

High or Low Blood Pressure

Anemia

Shortness of Breath/ Asthma

Tuberculosis (TB)

Pins & Needles in Arms/Hands

Cold Hands/ Cold Feet

Gall Bladder

Mid Back Pain/ Low Back Pain

Liver Trouble

Kidney and/or Bladder Trouble

Constipation/Diarrhea

Pinched Nerves in Back

Disc Problems

Sexual Dysfunction

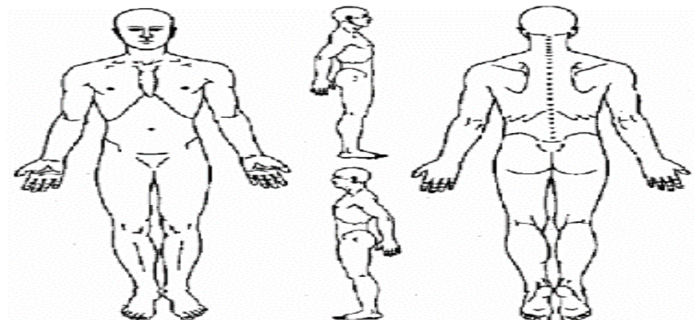
Pains in Feet and/or legs

Cancer

Stomach Trouble/ Indigestion

Diabetes

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



Who is responsible for your bill?
You and: Personal Insurance Medicare Workers Comp Auto

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

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.
4. I understand that I am fully responsible for my bill.
5. I authorize use of this form on all my insurance submissions.
6. I authorize release of information to all my insurance companies and direct payment to this provider
7. I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.

Permission to share medical information.

I authorize the release of information to the following individuals listed in the spaces blow (Ex: Spouse, Children, other Family Members):

Name/Relationship:____

"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 limitations for services covered in our office. According to your specific plan, the following services may not be covered:

Examinations, Re-examinations, X-rays, 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 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 our staff).

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 our staff).

X-rays

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

Patient Name (Printed) ____________________________________ D.O.B ___ / ___ / ___
X Patient/ Guardian Signature ________________________________ Date: ___ / ___ / ___