Patient Intake Form

Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

General Information

Name _____ Date _____

Street Address _____

City _____ State _____ Zip Code _____

DOB _____ ☐ male ☐ female Marital status S M W D SEP

Email Address _____

PHONE NUMBER Home _____ Cell _____

Occupation _____ Employer _____

WOMEN ONLY: Are you pregnant? ☐ yes ☐ no If yes, how many months? _____

Insurance Information

Primary Insurance

Insurance Company _____

Insured Name _____ DOB _____

Relationship to Insured _____

Secondary Insurance (if applicable)

Insurance Company _____

Insured Name _____ DOB _____

Relationship to Insured _____

Have you seen another chiropractor/therapist this year? YES NO

If YES, how many visits? _____

Please list any medication you are currently taking and why:

_____

PLEASE TURN OVER AND FILL OUT BACK

Patient Intake Form

Give a brief description of the problem you are currently experiencing

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? ☐ Yes ☐ No

When does it bother you? ☐ Work ☐ Sleep ☐ other _____

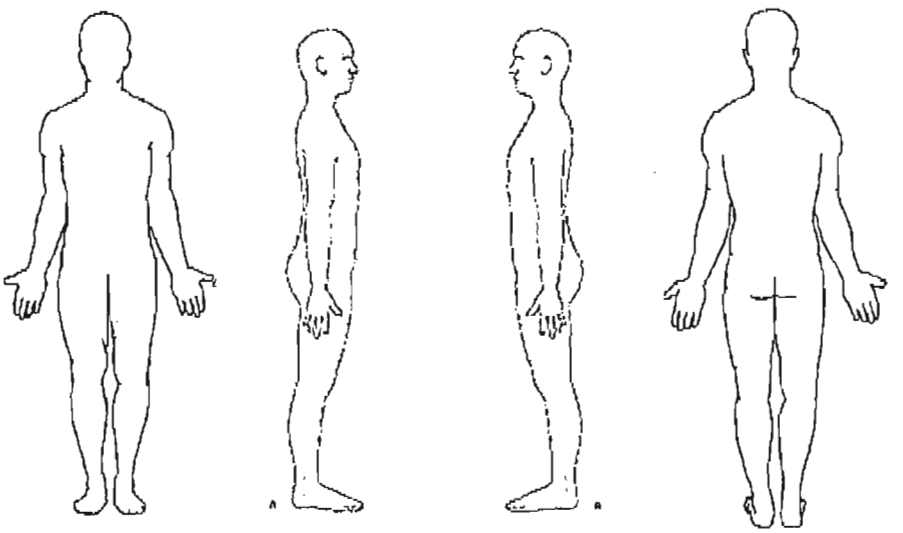
What seemed to be the initial cause? _____

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain

Please mark your area(s) of pain on the figure below



Past Health History

Have you...	Yes	No	If yes, explain briefly
been hospitalized in the last 5 years?	☐	☐	_____
had any mental disorders?	☐	☐	_____
had any broken bones?	☐	☐	_____
had any strains or sprains?	☐	☐	_____
ever used orthotics?	☐	☐	_____
Do you take minerals, herbs or vitamins?	☐	☐	_____

How is most of your day spent? ☐ sitting ☐ standing ☐ other _____

When was your last physical exam? _____

Family History *If any blood relative has had any of the following conditions, please check and indicate which relative(s)*

☐ Alcoholism	☐ Cancer	☐ High Blood Pressure
☐ Anemia	☐ Diabetes	☐ High Cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple Sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed Easily	☐ Heart Disease	☐ Thyroid Disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Douglas Catoggio, D.C., ART

537 Bedford Avenue
Bellmore, NY 11710
(516) 377-9090

I hereby give permission to have my personal insurance information sent via fax, mail, phone, or by electronic transmission. I understand that this is done for insurance purposes.

Signature: _____
Date: _____

I hereby give permission to the above stated office, and that of Dr. Catoggio to use this information strictly for insurance purposes within that of the HIPAA regulations.

Signature: _____
Date: _____

Advanced Chiropractic of Merrick
Dr. Douglas Catoggio

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Advanced Chiropractic of Merrick

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for chiropractor is also posted in the waiting room at 537 Bedford Ave. this Notice of Privacy Practices also describes my rights and duties of the chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Rep. Printed Name of Patient

_____

Date of Signing