

PATIENT INTAKE

Date: _____

Confidential Patient Information

Patients Name: _____

What do you prefer to be called: _____

Address: _____

Home Phone: _____

City: _____ Zip: _____

Cell Phone: _____

SS#: _____

Work Phone: _____

Date of Birth: _____ Age: _____

Male () Female () Marital Status: M S W D

Name of Spouse: _____

Number of Children: _____

Employer: _____

Email: _____

Occupation: _____

Work Address: _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___ No

Ins. Company: _____

Ins. Phone #: _____

ID#: _____

Group #: _____

Name of Policy Holder: _____

Policy Holder DOB: _____

Policy Holders Employer: _____

Address of Insured (if different than above): _____

Do you have a secondary insurance: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Why? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? If so, Where? _____

What operations have you had & when? _____

Any other serious trauma, health/psychological problems, serious illness, or infectious disease & when: _____

Do you have a pace maker? Y / N Hip or Knee Replacements Y / N Allergies Y/N _____

Medications/supplements are you taking? (check those that apply): (Pain Killers) (Insulin) (Cholesterol Meds) (Blood Pressure Meds) (Muscle Relaxers) (Birth Control) Other: _____

What is your goal in our office?

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to 1st Choice Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expense.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

X

SIGNATURE OF INSURED/GUARDIAN

DATE