

PATIENT INTAKE FORM AND CASE HISTORY

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will work to refer you to the appropriate health care provider.

PERSONAL INFORMATION

Name: Dr. Mr. Mrs. Ms Miss _____

SSN: _____-_____-_____

Date of Birth: ____/____/____

Address: _____

Phone: (H) _____

(W) _____

City _____ State _____ Zip _____

(C) _____

Email: _____

Best Time to Reach You: AM Noon PM

Employer: _____

Occupation: _____

Work Address: _____

City _____ State _____ Zip _____

Marital Status: M S W D

Spouse's Name _____

Children's Names and Ages: _____

Emergency Contact Name: _____ Contact Phone: _____

Whom may we thank for referring you to us? _____

Primary Care Physician: _____ Affiliated with Group? _____

Address: _____ Phone: _____

RESPONSIBLE PARTY / INSURANCE INFORMATION

Name of Primary Insured: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____-_____-_____

Employer: _____ Work Phone: _____

Work Address: _____

Insurance Company: _____ Phone: _____

Group Number: _____ Employer Number: _____

Have you met this year's deductible? Y N

Do you have additional insurance (Secondary)? Y N If yes, please complete the following.

Insurance Company: _____ Phone: _____

Group Number: _____ Employer # / ID # _____

Have you met this year's deductible? Y N

HEALTH INFORMATION

Please check all that apply with regard to your reasons for consulting our office:

- I have a specific problem and require help only with this problem
- After my specific problem has been relieved, I am interested in strategies to ensure this problem does not return. (Maintenance)
- After my specific problem has been relieved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health. (Wellness)
- Neck Pain Mid-back Pain Low Back Pain Joint Pain
- Headache
- Respiratory Problems
- Abdominal Problems
- Other; please specify: _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past N Y, when? _____

What activities aggravate your condition? _____

What makes it better? _____

Is this condition getting progressively worse? Y N Constant Comes and goes

Is this condition interfering with your activities? N Y(check all that apply) Work Sleep Daily Routine

Have you seen any other health professional for this condition? N Y; name, when and what was the outcome?

Please list any surgeries (with year completed): _____

Please list any prescription drugs, OTC drugs, vitamins and supplements you are currently taking: _____

Do you wear: Heel lifts Sole lifts Insoles Arch supports Orthotics None of these

Have you been in an auto accident? Never Past year Past 5 years Over 5 years ago

Description of Accident _____

Date of most recent physical exam: _____

Environment / Lifestyle:

	<input type="checkbox"/> Y <input type="checkbox"/> N	Amounts / Comments
Do you smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you drink alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you have a healthy diet?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you exercise regularly?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you sleep well at night?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Is your job stressful?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Can you think of any other habit or activity that has a positive or negative effect on your health?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

RADICE FAMILY CHIROPRACTIC FINANCIAL ARRANGEMENT

PRIVATE PAY

In order to qualify for cash pricing, payment is due at the time of treatment. If a patient cannot pay at the time of service, they are expected to pay regular fees, as set by insurance carriers and this office.

THIRD PARTY PAYERS

*Note: Insurance is an agreement between the patient and the insurance company, not the doctor. Treatment plans should be administered according to the patient's needs. Occasionally, patients may need treatment beyond their insurance's coverage. It is important that both patient and doctor keep the patient's health interests and goals in focus.

INSURANCE

If you have insurance that covers chiropractic care, Radice Family Chiropractic will be glad to fill out all paperwork regarding your condition and treatment. We will file directly for payment of services rendered after verbal verification of your coverage from your insurance carrier. As the patient, you will be responsible for any fees or services not covered by your insurance policy. Any co-pay or deductible will be paid at the time of service.

AUTOMOBILE INSURANCE (PIP)

If you have been in an automobile accident and would like to file with your automobile insurance, Radice Family Chiropractic will deal directly with the insurance company provided they will accept an assignment of benefits. An assignment of benefits indicates that the insurance company will make payments directly to Radice Family Chiropractic for the services rendered and billed.

WORKMEN'S COMPENSATION

In order for your Workmen's Compensation claim to be valid, Radice Family Chiropractic must have verbal as well as written authorization for treatment from your employer as well as verbal authorization from the employer's Workmen's Compensation carrier. One of our staff will do this before or during your first visit.

If you have any questions regarding our policies listed above please ask the front desk staff. We can assist you in filling out any forms as well as explain payment arrangements that are in line with Radice Family Chiropractic's financial arrangement.

I have read, fully understand and agree to abide by Radice Family Chiropractic financial arrangement policies that pertain to me. I furthermore acknowledge and agree that I am responsible for paying Radice Family Chiropractic their fee for treating me and at any time, Radice Family Chiropractic can demand payment for all or part of the balance of said fee. I also agree to pay all of Radice Family Chiropractic's expenses to collect that fee, including reasonable attorney costs.

Responsible Party

____/____/____
Date

Radice Family Chiropractic Representative

____/____/____
Date

PATIENT CONSENT TO X-RAY

I, _____ authorize the performance of diagnostic x-ray examination on myself which Dr. Radice or the appropriate staff consider necessary or advisable in the course of examination and treatment.

Signed

____/____/____
Date

VERIFICATION OF NON-PREGNANCY

This is to certify that to the best of my knowledge, I, _____ am not pregnant and that Dr. Radice or the appropriate staff has my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____.

Signed

____/____/____
Date

CONSENT TO X-RAY A MINOR

I, _____, authorize the performance of diagnostic x-ray examination of my child or ward which Dr. Radice or the appropriate staff consider necessary or advisable in the course of examination and treatment. The patient, _____ is a minor, _____ years of age.

Signed

____/____/____
Date

