Vincent Chiropractic Intake Form

Patient Full Legal Name: _____ Today's Date: _____
Phone Number: _____ Email: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Sex: _____ Age: _____ DOB: _____ Marital Status: _____
Employer/School: _____ Occupation: _____

EMERGENCY CONTACT: Name: _____ Relationship: _____
Cell Phone Number: _____ Work Phone Number: _____

INSURANCE INFORMATION:
Subscriber Name: _____ DOB: _____
Relationship to Patient: _____ Insurance Company: _____
Subscriber Number: _____ Group Number: _____
Is the patient covered by additional insurance? _____ Yes _____ No
Secondary Insurance Information: _____
_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Dr. Megan Vincent** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when I end treatment.

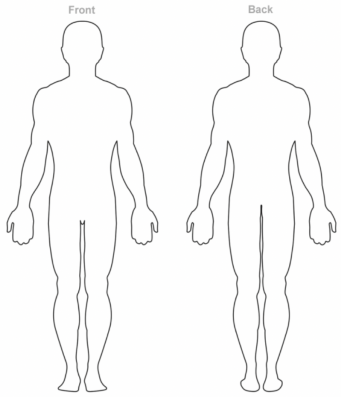
_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

ACCIDENT INFORMATION: Is this condition due to an accident? ____ NO ____ YES
Date of accident: _____ Type of accident: ____ Auto _____ Work
To whom have you made a report of your accident? ____ auto insurance __ Employer ____ Workers Comp
Attorney name and number (if applicable): _____

PATIENT CONDITION:
Reason for visit: _____
When did your symptoms appear? _____
Is this condition getting worse? __ Y ____ N
Rate severity of symptoms on a scale of 1 (least) to 10 (worst): _____
Please *circle* type of pain:
Sharp Dull Throbbing Numbness Aching
Shooting Burning Tingling Cramps Stiffness Swelling
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with work? _____ sleep? _____
Which activities are painful to perform?
__ sitting __ standing __ walking __ bending __ lying down



HEALTH HISTORY:

What treatment have you already received for your condition? _____
Name and address of other doctor(s) who have treated you for your condition
_____

Please ***circle*** if you have had any of the following:

AIDS/HIV	Diabetes	Liver Disease	Rheumatoid Arthritis
Alcoholism	Emphysema	Measles	Rheumatic Fever
Allergy Shots	Epilepsy	Migraines/Headaches	Scarlet Fever
Anemia	Fractures	Miscarriage	STDs
Anorexia	Glaucoma	Mononucleosis	Stroke
Appendicitis	Goiter	Multiple Sclerosis	Suicide Attempt
Arthritis	Gonorrhea	Mumps	Thyroid Problems
Asthma	Gout	Osteoporosis	Tonsillitis
Bleeding Disorders	Heart Disease	Pacemaker	Tuberculosis
Breast Lump	Hepatitis	Parkinson's Disease	Tumors/Growths
Bronchitis	Hernia	Pinched Nerve	Typhoid Fever
Bulimia	Herniated Disc	Pneumonia	Ulcers
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	High Blood Pressure	Prostate Problem	Whooping Cough
Chemical Dependency	High Cholesterol	Prosthesis	Other _____
Chicken Pox	Kidney Disease	Psychiatric Care	_____

EXERCISE:	**WORK ACTIVITY:**	**HABITS:**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavily	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you currently pregnant? ____ No ____ Yes Due Date: _____

Past Injuries/Surgeries:	**Description**	**Date**
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/SUPPLEMENTS**
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone: _____	_____	_____

Vincent Chiropractic

Patients Name: _____ Date: _____

Age: _____ Gender: _____

FAMILY HISTORY (please include which family member):

High Blood Pressure:

Heart Disease:

Diabetes:

Cancer:

Other:

VINCENT CHIROPRACTIC
4105 WEST MAIN STREET ROAD
BATAVIA, NY 14020

HIPAA COMPLIANCE PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE.

PATIENT'S NAME:_____

DATE OF BIRTH:_____

TO GIVE CONSENT TO DISCLOSE HEALTH CARE INFORMATION TO SOMEONE OTHER THAN THE PATIENT, PLEASE WRITE THEIR NAME BELOW: (E.G. FAMILY MEMBER, CARETAKER)

NAME:_____

I UNDERSTAND THAT MY HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT **VINCENT CHIROPRACTIC** WORKS VERY HARD TO PROTECT MY PRIVACY AND PRESERVE THE CONFIDENTIALITY OF MY PERSONAL HEALTH INFORMATION.

I UNDERSTAND THAT SIGNING THIS DOCUMENT MEANS THAT **VINCENT CHIROPRACTIC** MAY USE AND DISCLOSE MY PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTHCARE TO ME, TO HANDLE BILLING AND PAYMENT, AND TO TAKE CARE OF OTHER HEALTH CARE OPERATIONS. FAILURE TO SIGN THIS CONSENT MAY RESULT IN THE PHYSICIAN DECLINING TO TREAT ME.

UNDER THE TERMS OF THIS CONSENT, I CAN ASK **VINCENT CHIROPRACTIC** TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I UNDERSTAND THAT **VINCENT CHIROPRACTIC** DOES NOT HAVE TO AGREE TO MY REQUEST. IF HE DOES AGREE TO MY REQUEST, I UNDERSTAND THAT HE WOULD FOLLOW THE AGREED LIMITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO CANCEL THIS CONSENT IN WRITING AT ANY TIME. IF I DO CANCEL THE CONSENT, I UNDERSTAND THAT **VINCENT CHIROPRACTIC** MAY HAVE ALREADY USED OR DISCLOSED INFORMATION ABOUT ME AND CANCELING THIS CONSENT WOULD NOT AFFECT THE INFORMATION ALREADY USED OR DISCLOSED.

May we phone, email or send a text to you to confirm your appointment?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with another member of your family?	YES	NO

If YES, please name the members allowed: _____

I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

WRITING, SIGNING, AND DATING A LETTER TO **VINCENT CHIROPRACTIC** THAT SAYS I WANT TO REVOKE MY CONSENT TO AUTHORIZE THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS.

I UNDERSTAND IF I CANCEL THIS CONSENT, **VINCENT CHIROPRACTIC** IS NOT OBLIGATED TO PROVIDE FURTHER HEALTH CARE SERVICES TO ME.

MY SIGNATURE BELOW INDICATES THAT I AGREE TO THE POLICIES OUTLINED BY THIS DOCUMENT AND ALL STATEMENTS THEREIN.

_____

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE **DATE**

_____

RELATIONSHIP TO THE PATIENT IF SIGNED BY ANYONE OTHER THAN HIM/HER (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)