Pelosi Chiropractic and Wellness Center Inc

New Patient Intake Form

Date_____ **Patient #**_____

How did you hear about us? _____ Sex: Male Female

Name _____ Date of Birth: _____/_____/_____ Age: _____

Address: _____City: _____State: _____ Zip: _____

Home Phone _____ Cell Phone _____Work Phone_____

Email _____ Marital Status: Single Married Widowed

Social Security Number: _____-_____-_____

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer _____ Occupation _____

Spouse Name _____ Occupation _____

Emergency contact name _____Relationship to Patient_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Worker's Comp Auto Insurance
Medicare Medicaid Other _____

Health Insurance Carrier: _____ Ins. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury :

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____am / pm

Auto / Personal Injury:

Date of Accident: _____
Auto Insurance Company: _____ Claim # _____
Attorney Name: _____ Phone: _____

I hereby authorize payment to be made directly to **Pelosi Chiropractic and Wellness Center Inc**, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Pelosi Chiropractic and Wellness Center for any and all services I receive at this office.

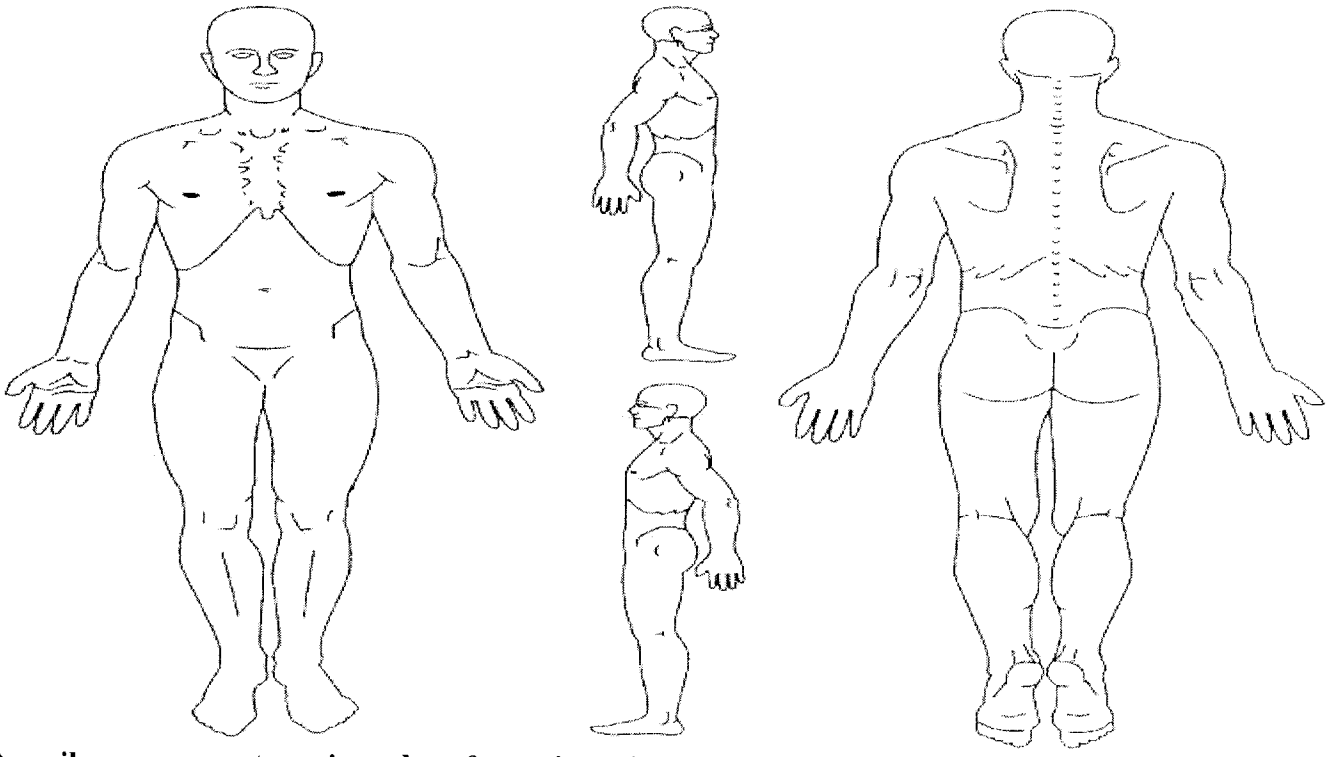
Patient signature_____**Date**_____

Patient Name _____ **Date** _____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

On a scale of 1 to 10, rate your pain (circle the number): 1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? Month_____ Day_____Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin?

_____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

Patient Name _____ **Date** _____

Have you seen a chiropractor/massage therapist before? □ NO □ YES Last Visit: _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _____			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Wear Seat Belts:	occasional	always	never

Other _____

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Check one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

List of prescription & non-prescription medication you take _____

_____

_____

Informed Consent for Treatment

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **Pelosi Chiropractic and Wellness Center Inc** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*
Patient or Authorized Person's Signature **Date**

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)
☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.
By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*
Patient or Authorized Person's Signature **Date**

Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has been advised that a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Medical Information Release Form (HIPAA Release Form):

Release of Information:

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____ ( ) Children _____
( ) Other _____ ( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Print Patient's Name _____

Patient's Signature _____ **Date**_____

Pelosi Chiropractic and Wellness Center
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.