Harris Chiropractic Clinic

New Patient Intake

Name: _____ Today's date: _____

Date of Birth: _____ Sex: M___F ___ SS#: (just the last 4 digits) _____

Address: _____ Apt/Suite#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Primary Phone (Circle one): Home - Work - Cell Email: _____

Are you married? Yes No Spouse's name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Will we be filing insurance for you? Yes No If yes, insured name: _____

Insured Date of Birth: _____ Relationship to Insured: _____

Insured address (if different from patients): _____

Apt/Suite#: _____ City: _____ State: _____ Zip Code: _____

Employment Status: Full-Time__ Part-Time___ Unemployed__ Retired__

Employer: _____

Student Status: Full-Time__ Part-Time__ School: _____

Primary Care Physician: _____

Patient's Name_____ Date Symptoms began: _____

1). Briefly describe your symptoms: _____

_____

2). How did your symptoms start? _____

_____

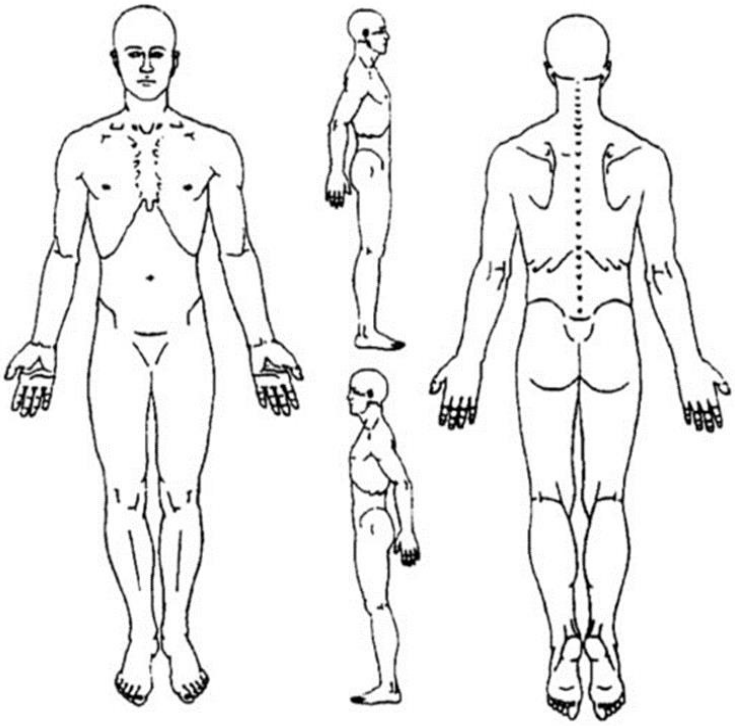
3). Average pain intensity ('0' being no pain and '10' being the worst pain)?

Last 24 hours: _____ Past Week_____

4). What is the frequency of the pain?

_____Constant (75%-100% of the time)
_____ Frequent (40%-75% of the time)
_____ Occasional (25%-50% of the time)
_____ Intermittent (0%-25% of the time)

PLEASE CIRCLE AREAS OF COMPLAINT



5). How much have your symptoms interfered with your daily activities?

_____ Not at all _____ A little bit
_____ Moderately _____ Quite a bit
_____ Extremely

6). Please list prior surgeries: _____

_____

_____

7). Please list current medications: _____

_____

_____

8). Any allergies to medication? _____

_____

_____

(Circle one)

9). Do you smoke: Never Not currently (quit date_____) YES (How many years?_____)

MEDICAL HISTORY INFORMATION SHEET

NAME: _____ **AGE:**_____ **TODAY'S DATE:** ____/____/_____

Birth Date: (M / D / Year) _____/_____/_____ **Height** ____**ft**____**inches** **Weight** _____**lbs**

REASON FOR TODAY'S EXAM _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

__High Blood Pressure __ DVT Lung Disease __ Stroke __High Cholesterol __ Pulmonary Embolus __ Asthma

__ Diabetes __Vein Trouble __ Tuberculosis __ Heart Trouble __ Pneumonia __ Kidney Disease __ Nervous Disorder

__Seasonal Allergies__ HIV__ Thyroid Problems__ Sinus__ Arthritis__ Hepatitis__ Drug Abuse/Alcoholism

__Tonsillitis __ Gastrointestinal __ Osteoporosis __ Joint Replacement __ Bleeding Tendencies __

Cancer: If Yes, What Type _____ Other: _____

History of Serious Injuries / Illnesses? **YES/NO** If yes, please describe below.

_____

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

_____

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions **immediate FAMILY** has had.

High Blood Pressure ___ DVT ____ Lung Disease ____ Stroke ____ High Cholesterol_____

Pulmonary Embolus ____Asthma ____ Diabetes _____ Vein Trouble _____ Tuberculosis_____ Heart Trouble_____

Pneumonia ____Kidney Disease_____ Nervous Disorder _____ Seasonal Allergies _____ HIV ____

Liver Disease ____ Seizures____ Ear Problems ____ Sinus ____ Drug Abuse / Alcoholism ____ Thyroid Problems _____

Arthritis ___ Tonsillitis ___ Joint Replacement ___ Hepatitis ____ Gastrointestinal ___ Osteoporosis ____

Cancer: Type_____

SOCIAL HISTORY: Occupation: _____ **Marital Status**:_____ **Children: Yes/ No_____**

Live Alone: Yes/ No Tobacco Use: Never/ In the Past/ Presently: How Much? _____ **How Long?** _____

Alcohol Use: Daily/ Occasional/ None/ Other substance use or abuse? Yes /No _____

SYSTEM REVIEW: Please describe any **active problem or symptom**. General Symptoms (i.e. fever, weight gain/loss, fatigue) _____

Eyes/Ears/Nose/Throat _____ Heart _____ Lung _____ Allergies/Rashes _____

Muscles/Bones/Joints _____ Psychiatric _____ Endocrine (Diabetes/Thyroid)_____

Bleeding/Lymph Nodes _____ Nerves _____ Skin and/or Breasts _____

OB/Genital/Urinary _____ Abdomen _____

ALLERGIC TO LATEX: Yes /No ALLERGIC TO MEDICATIONS: Yes /No PLEASE LIST:_____

_____

CURRENT MEDICATIONS: _____

How will payment be made?_____Health Ins ____ Auto Ins_____Self-Pay_____Other

Are you covered by Medicare?_____Yes_____No

I hereby attest that the above information is true and accurate to the best of my knowledge. I hereby authorize the doctor or his representative to examine and treat me for my injuries and related illnesses as they deem appropriate. **I understand that fees for professional services from Harris Chiropractic Clinic are due and payable at the time of the visit**, unless other arrangements have been made. I understand that copies of my office records are available and may be obtained by filling out and signing the appropriate medical record release form, and that there may be a fee for this service, not to exceed the usual and customary rates.

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that as a courtesy Harris Chiropractic Clinic will assist me in submitting my bills to my insurance carrier and in making collection from the insurance company, and that any amount authorized to be paid directly to the Harris Chiropractic Clinic, will be credited to my account upon receipt. However, by affixing my signature **below I agree that I am personally responsible for full payment of all goods and services rendered me** through this clinic, regardless of the type and amount of insurance reimbursement provided for these services from third party payers.

_____ _____

Patient's Signature Date

_____ _____

Patient's Name (Printed) Signature of parent for minors

Notice to all Patients

Welcome to our facility and practice! The following is important information regarding our patient policies. These policies aid us in ensuring proper care and customer services. If you have any questions or concerns, please do not hesitate in contacting our staff.

- Please sign in upon entering the facility for your scheduled appointment and check out with our receptionist prior to leaving. Please inform staff if your insurance, address or any other pertinent information changes.

- Payments are due at the time services are rendered unless prior arrangements have been made. Please be prepared to pay by credit card, check, or cash each office visit if necessary. **We will bill your insurance as a courtesy, but it is your responsibility to follow up on all insurance issues**. The billing department will do everything that can be done to resolve insurance issues, but it is your responsibility in the end.

- In order to provide all of our patients with proper care, it is imperative you arrive on-time for your scheduled appointment. It is imperative that you call if you are running late for your appointment, even being 5 minutes late may delay, shorten, or possibly cancel your appointment.

- **Failure to notify the clinic of cancellation of your scheduled massage therapy appointment at least 24 hours in advance will result in a $25 charge billed personally to you**. Your insurance company will NOT cover this fee.

- We value your time. If you have a limited amount of time for your session, please let us know in advance and we will accommodate you as best as we can.

Thank you for your patience and cooperation. By signing below, you certify that you agree to and understand the patient policies listed above.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By completing the lines below I,_____ authorize being contacted for practice reminders, information, and changes by:

PLEASE PRINT CLEARLY

Email at the following email address: _____
Telephone number(s) Cell Phone: _____
Other phone: _____
Is it okay to leave a voice message? Check here _____
Is it okay to leave a text message? Check here _____

Patient Name:_____ Date: _____

Name of parent, guardian, or patient's legal representative: _____

Signature of Patient, Guardian, or Patient's legal Representative: Date:

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI (Protected Health Information). This allows us to acknowledge that you are being treated here, discussion of your condition and/or allow them to pick up records on your behalf.

_____ _____

_____ _____

_____ _____

_____ _____

HARRIS CHIROPRACTIC CLINIC
DR. MARK HARRIS, D.C.,C.C.S.P
3592 Aloma Ave. Suite #3
Winter Park, FL 32792
407-706-1420

Doctors of chiropractic, medical doctors, osteopaths, and physical therapists using manual therapy treatments for patients with neck problems are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause stroke, sometimes with serious neurological injury. The chances of this happening are extremely remote, approximately 1 per 1 million treatments. Appropriate tests will be performed on you to help identify if you may be susceptible to that kind of injury. If you have any questions about this please do not hesitate to speak with Dr. Harris.

I have read and understood the above statement, accept the risk mentioned, and hereby consent to treatment.

Signature: _____ Date: _____

Witness: _____ Date: _____