Directions for filling out digital forms:

Type in all appropriate fields; print & sign. Bring into the office on the day of your appointment.

OR

Type in all appropriate fields and then email it to us at kjames@caringchironj.com. When you arrive to your appointment, you can then sign all documents.

caring CHIROPRACTIC

DOCTOR	Primary Office	Case Type

Patient Insurance Record

PATIENT INFORMATION

First Name	Last Name	MI	Phone #
Street Address	City	State	Zip
Social Security Number	DOB	C/D	Reffering Physician
Relationship To Insured	SELF ☐ SPOUSE ☐ CHILD OTHER		

INSURED INFORMATION (If Different From Patient)

First Name	Last Name	MI	Phone #
Street Address	City	State	Zip
Social Security Number	DOB	C/D	

HEALTH INSURANCE INFORMATION

Primary ☐ Secondary ☐

Insurance Company Name			Phone #
Policy Holder (Employer)			Phone #
Street Address	City	State	Zip
ID #	Group #		
Coverages			

AUTO INSURANCE INFORMATION

Primary ☐ Secondary ☐

Insurance Company Name			Phone #
Street Address	City	State	Zip
Policy #	Claim #	DOA	
CLAIM REPRESENTATIVE / ADJUSTER			Phone #
Coverages			

PRECERTIFICATION

	Case Manager	
Company Name	Phone #	Fax #

ATTORNEY INFORMATION

Name	Phone #	Fax #
Street Address	City	State	Zip

DX:

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PATIENT INTAKE FORM

PATIENT INFORMATION		
Name:		
Date of birth:	SSN:	
Address:		
City:	State:	ZIP Code:
Phone #:	Cell #:	Sex: M☐ or F☐(circle one)
Email:		May we contact you via: TEXT☐ EMAIL☐
Marital Status: S☐ M☐ D☐ W☐	# of children:	
Is your condition related to an accident? Y☐ or N☐	What type of accident? MVA☐ W/C☐ Slip & Fall☐ Other☐	Date of accident: (if applicable)

INSURANCE INFORMATION		
Primary Insurance:		
Address:		
City:	State:	Zip:
Phone #:	Policy #:	Group #:
Claim # (if accident):		
Secondary Insurance:		
Address:		
City:	State:	Zip:
Phone #:	Policy #:	Group #:
Claim # (if accident):		
Attorney (if applicable):		Phone #:
Address:		
City:	State:	Zip:

EMERGENCY CONTACT INFO		
Name:		
Relationship to you:		Phone:
Address:		
City:	State:	ZIP Code:

HEALTH INFORMATION

Have you ever had previous chiropractic care? YES☐ NO☐
What is your major complaint? _____
How long have you had this condition? _____
What aggravates your condition? _____
Is this condition getting progressively worse: YES☐ NO☐ Constant☐ Comes & Goes☐
Is this condition interfering with your: Work☐ Sleep☐ Daily Routine☐ Other☐
How long has it been since you really felt good: _____
Other doctors who have treated this condition: _____
List surgical procedures and dates: _____
_____
Drugs you now take: -Anti-Depressants☐ -Pain Killers☐ -Muscle Relaxers☐ -Energy Drinks/Stimulants☐ -Anxiety☐
Age of mattress: _____ -Comfortable☐ -Uncomfortable☐
Are you wearing: -Heal Lifts ☐ -Sole Lifts ☐ -Inner Soles ☐ -Arch Supports ☐
Have you ever been in an auto accident: - Past Year☐ -Past 5 Years☐ -Over 5 Years☐ -None☐
Have you ever had any other personal injury or accident? - Past Year☐ -Past 5 Years☐ -Over 5 Years☐ -None☐
Do you Diet?☐YES NO☐ If so explain:_____
Do You Exercise?☐YES NO☐ If so how much:_____

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PATIENT INTAKE FORM

EMPLOYER INFORMATION		
Employer Name:		
Address:		
City:	State:	ZIP Code:
Phone #:		
Occupation:		

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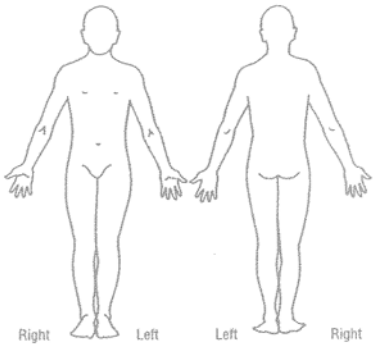
PATIENT INTAKE FORM

ACCIDENT DETAILS

Where did the accident occur?	
How did the accident happen?	Were you unconscious: YES☐NO☐
How were you hurt?	
Where were you taken after the accident?	
What was done for you there?	
Name of Doctor:	
What medication were you given?	
Are you still taking the medication? YES☐NO☐ If so, how often and how much?	
Have you seen any other doctors? YES NO☐ If so, name and phone #:	
What was told was wrong with you?	
What are your present complaints?	
Have you ever had surgery? YES☐ NO☐ If so, give date(s) and condition(s):	
Any ongoing/chronic illnesses?	

HEALTH QUESTIONAIRE AND PAIN LEVELS

Please mark your areas of pain: Complete after Printing.



Please rate your discomfort for each area:
(0=no pain 10= severe pain)

Neck/Shoulder Pain =
Mid Back Pain =

Low Back and Leg Pain =

Have you ever suffered from:	YES	NO
Dizziness or Fainting		
Blood in urine or stool		
Chest Pain		
Abdominal Pain		
Inability to hold urine or bowel		
Blurry Vision		
Pain at Night		
Difficulty Breathing		
Spitting up blood		
Bruise easily		
Cancer		
Digestion Problems		
High Blood Pressure		
Diabetes		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that I suspend or terminate my care and treatment; any fees for professional services rendered me will be immediately due and payable.

We at this office are dedicated to providing you with the finest care possible. However, in order for us to best treat your condition, your cooperation is necessary. When the doctor prescribes a treatment schedule, it is for your maximum benefit and these appointments must be kept. Please understand that missed appointments yield less than ideal results and hinder your progress toward recovery. Should you miss a scheduled appointment, we ask that the appointment be made up within the same week. Persistent failure to keep scheduled appointments may result in our having to document non-compliance on the part of the patient, notification to your attorney, if represented, or possible discharge before recovery has been attained. I acknowledge that I have read the above, and will make a concerted effort to comply with any prescribed treatment schedule.

I have read and hereby state that everything written above is true and correct.

Patient Signature:	Date
Guardian/Parent Signature:	Date

HEALTHCARE AUTHORIZATION FORM

Patient's Name: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ***(Caring Chiropractic)*** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ☐ I give permission to **(Caring Chiropractic)** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards, emails, and/or text messages as well as information about treatment alternatives or other health related information.

(OPEN ROOM AUTHORIZATION - OPTIONAL)

- ☐ I give **(Caring Chiropractic)** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak with the Doctor at any time in private, the Doctor will provide a room for those conversations.

- ☐ By signing this form you are giving **(Caring Chiropractic)** permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **[Caring Chiropractic]**. The written notice must contain the following information:

- Your name, Social Security number, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request;
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **(Caring Chiropractic)** for its own use/disclosure of protected health information. ***(Minimum necessary standards apply.)***

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **(Caring Chiropractic)** will NOT refuse to provide treatment.

You have the right to inspect or copy the protected health information to be used/disclosed.

_____

Name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Personal Representative Date

_____

Description of Representative's Authority to act for Patient