NEW PATIENT INTAKE FORM

Patient Information:

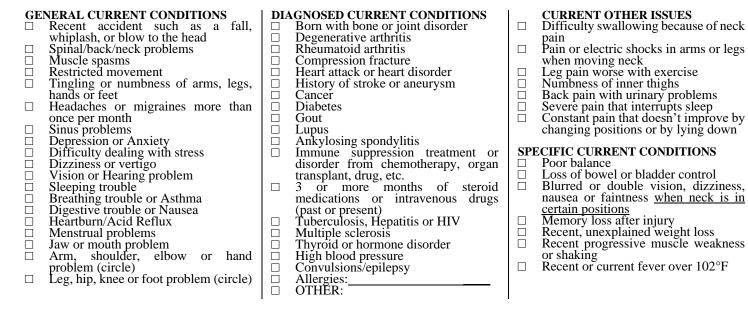
	questions do not hesitat	blete this form in ir e to ask for assista		•	lp.	
(Please Print) Name		Date		Patient No.	S/S	
First	MI	Last			575_	
Address			City		State	Zip
Email address:						
Birth Date Home Phone #			Work Phone #			
Your current Pri		City May we cont		we contact th	nem?	
🗖 No 🗖 Yes						
	or 🗖 Married 🗖 Divorc					
Your Employer		Occ	upation			
Business Address			City		State	Zip
Spouse's or Parent	Workp	Workplace		Work Phone#		
Whom may we that	ank for referring you to us	?				
Person to contact i				Phone #		
Insurance In	formation					
	y have insurance? 🗖 N stercard &discover	lo 🗖 Yes. IF NO fo	or your conv	enience we acc	cept cash,	
Insurance Company Name			(please note we do not accept all insurances)			
Insurance Card Nu	umber					
Do you have a dec	luctible?					

Symptoms

Reason for Surgery	When did you first notice the
symptoms?	
Is this injury the result of a work related incident or automobile	e accident?
Is this condition getting progressively worse?	
Where specifically is the problem(s) located?	
Which activities are difficult to perform? \square Sitting \square S	tanding 🗖 Walking 🗇 Bending 🗖 Lying Down
Type of Pain: 🗆 Sharp 🗖 Dull 🗖 Throbbing 🗖 Numbre 🗖 Burning 🖨 Tingling 🖨 Cramps 🖨 Stiff	
Rate the severity of your pain. (1, mild pain or discomfort, to 1	0, severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go?	
What other treatment have you already received for you	ur condition? 🗖 Medication 🗖 Physical Therapy
(Women) Are you pregnant? 🗖 Yes 🗖 No Taking birth	control pills? 🗖 Yes 🗖 No
List any types of surgeries which you have had and the dates w	hich they occurred:
Please list all medications you are currently taking:	
Allergies:	
Daily Habits	
What type of exercise do you perform on a daily basis?	🗖 None 🗖 Moderate 🗖 Heavy
What do your daily work habits include? (ex: sitting, standing,	light labor, heavy labor, computer work, etc.)
Do your currently wear orthotics?	
Do you smoke? 🗖 Yes 🗖 No How much per day?	
How much coffee or caffeinated beverages do you consume on	a daily basis?

Health History

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.



Our Privacy Policy

The surgery center is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. In accordance with the

Health Insurance Portability and Accountability Act of 1996 (HIPPA) we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with surgery center. may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare. Members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone/email and you are not at home a message will be left on your answering machine.

Assignment of Insurance Payments

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Waldman Chiropractic 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 me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

By signing below, I have read, or have had read to me, and agree to the above Privacy Policy Assignment of Insurance Payments, and that I certify that my confidential medical information presented is correct to the best of my knowledge.

Patient or Guardian's Signature_____

Date _

Patient's Name (PRINTED)