



The New Life Chiropractic Center

6550 Mercantile Dr., E, Ste 105 Frederick, MD 21703
301-668-2222

Patient Intake Forms

Patient Info

Name: _____ Preferred Name: _____ Date: _____
 Address: _____
 Home Phone: _____ Work: _____ Cell: _____
 E-mail: _____ Email will be used for newsletters & updates only.
 Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: M F
 Occupation: _____ Employer: _____
 Marital Status: Single Married Separated Divorced Widowed
 Spouse's Name: _____ Spouse's Occupation: _____
 Do you have children? Y N If yes, how many & what age/s? _____
 Emergency Contact: _____ Relationship: _____ Phone #: _____
 Referred By: _____ Primary Care Physician: _____

Insurance

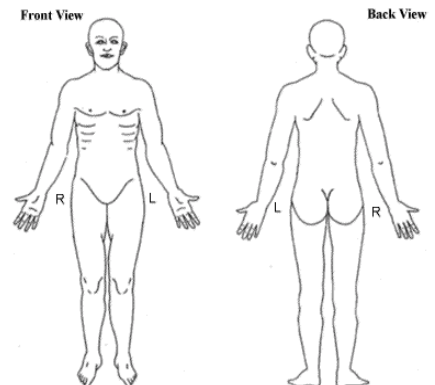
Policy Subscriber: _____ SSN: _____ Relationship to patient: _____
 Insurance Company: _____ Subscriber ID: _____ Group #: _____
 Is there secondary insurance coverage? Y N If yes, please fill in appropriate information.
 Policy Subscriber: _____ SSN: _____ Relationship to patient: _____
 Insurance Company: _____ Subscriber ID: _____ Group #: _____
 Please present insurance card/s so we can put a copy in your file.

Accident Info

Is your condition due to an accident? Y N If yes, date of incident _____
 Type of accident? Automobile Work Employer Other _____
 To whom have you reported the accident? Insurance Worker's Comp Employer Other _____
 Insurance Company: _____ Phone #: _____ Claim #: _____
 Attorney Name & Phone # (If applicable) _____

Patient Condition

What is your major symptom/problem? _____
 When did your symptoms begin? _____
 Did it begin: Gradually Suddenly Progressed over time
 Have you had this problem before? _____
 Is your condition getting progressively worse? Yes No
 Is this problem: Constant Comes and goes
 Does it feel? Burning Sharp Shooting Dull Achy Stiff
 Tingling Throbbing Swelling Other _____
 Does your pain radiate into your: Arms Hands Legs Feet Head
 Circle below the severity of your pain on a scale of 0 to 10:
 (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)
 What makes your condition better? _____
 What makes your condition worse? _____
 Does it interfere with your: Work Sleep Daily Routine Recreation
 Activities/movements that are painful to perform: Sitting Standing Walking Bending
 Lying down Reading Getting Up Reaching



Please mark where it hurts

Health History

What other treatments have you had for this condition?

Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery

Name/s of other doctors who have treated you for this condition: _____

Describe any treatment received: _____

Previous Chiropractic Care? Yes No If yes, what doctor/facility? _____

Have you had any X-rays or MRI's? Yes No If yes, where were they taken? _____

List any medications you are taking: _____

Vitamins/Herbs/Supplements: _____

Females only: Are you Pregnant? Yes No Beginning of last menstrual cycle: _____

Are you Nursing? Yes No

Check any of the following conditions/diseases you have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Headaches-Migraines | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Swine Flu |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Earache | <input type="checkbox"/> MRSA | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other: |

Stressors

- Smoking
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

Exercise

- None
 Moderate
 Daily
 Heavy

Have you had any?

	Description	Date
Automobile Accidents	_____	_____
Surgeries	_____	_____
Broken Bones	_____	_____
Falls/Head Injuries	_____	_____

Authorization

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorized The New Life Chiropractic Center & Dr. Steven Digles D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Signature

Date

Parent (if patient is a minor)

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ***THE NEW LIFE CHIROPRACTIC CENTER*** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to The New Life Chiropractic Center (NLCC) to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday and holiday related cards, information about treatment alternatives, and other health related information.
- If NLCC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give NLCC 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 care. Should I need to speak with the doctor at any time in private, he will provide a room for these conversations.
- By signing this form you are giving NLCC 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 only, at any time. However your written request to revoke this authorization is not effective to the extent that we have provided services or take action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice the Privacy Official of The New Life Chiropractic Center. The written notice must contain the following information:

- Your name, date of birth, and social security number
- A clear statement of your intent to revoke this authorization
- The date of your request and your signature

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

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU IF REQUESTED.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provided a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: the right to review the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor)

The New Life Chiropractic Center

Experience New Health, Hope, and Life

Patient Policies

Payment Policies

We do everything possible to significantly minimize the cost of your care. We have found the administrative expense of billing patients increases our overhead, and you can help us keep your cost down by eliminating the need for us to bill you. The following is summary of our payment policy.

All payment is expected at the time of service/check-in

Payment is expected at time of check-in unless you are on a payment plan. This includes applicable co-insurance, estimated co-insurance and co-payments for participating insurance companies. We accept cash, personal checks, Visa, MasterCard and Discover.

Payment Options

We can make our care affordable to most everyone due to our different payment options. We have searched far and wide for a health financing company that accepts most everyone who needs care. By having this connection we can work with you if you need different payment options.

Insurance

We bill participating insurance companies as a courtesy to you. In our experience, we have learned that many insurance companies are scoundrels. Sometimes they delay payment, deny services and in general make life difficult. We will do our best to try to help you in this process. If we have not received payment from your insurance company in a timely manner (45-60 days), you are expected to pay your balance in full. You are ultimately responsible for all charges.

Questions

If you need any help or have questions, please call our office between 9:00 a.m.-5:00 p.m., Monday through Thursday at 301.668.2222.

Missed Appointments /Untimely Cancellations

Please give 24-hours notice if you have to miss an appointment. We understand this is not always possible. We will work with you, but if you make a habit of missing appointments, we reserve the right to charge for missed or untimely cancelled appointments.

❖ I have read the above information, understand it and will abide by it.

Patient Name: _____ Date: _____

Office Staff: _____ Date: _____