NEW PATIENT INTAKE FORM

Date: _____ Social Security No.: _____ DOB: _____

Name: _____ Spouse Name: _____

Address: _____ City: _____ State: _____ Zip: ___

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Race: _____

Ethnicity: □ Hispanic □ Non Hispanic Language: _____ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Employer: _____ Occupation: _____

Referred to this Clinic by: _____

Who is responsible for your bill? □ Self □ Spouse □ Employer □ Insurance □ Attorney □ Other

Name of insured person (if applicable) _____ Insured's Birth date _____

How will payment be made? □ Cash/Check/Credit Card □ Worker's Compensation □ Medicare

□ Health insurance □ Auto insurance □ Attorney

Name of primary insurance co.: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: ___

ID #: _____ Group #: _____

Health History: Please list all of your health history including Surgeries, X-rays, MRIs or any current diagnoses:

_____

_____

_____

Family History: □ Heart disease □ Heart attacks □ High blood pressure □ Strokes □ Diabetes I/II □ Cancer/tumors
Which family member? _____

Medications: _____

_____

Allergies to medications: _____

Tobacco Use…….□ Yes □ No If yes, How much/many a day? _____ How many years? _____
Alcohol Use……..□ Yes □ No If yes, how many drinks per week? _____
GFCC has my permission to x-ray me if necessary: □ Yes □ No
Are you currently pregnant? □ Yes □ No □ Maybe

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with the personal physicians and other healthcare providers and payors and to secure the payment of benefits. **I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage.** I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
The patient understands and agrees to allow GFCC to use their patient health information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information:

_____

_____

Patient (or guardian) Signature and Date

Name: _____ Date: _____

How did this condition develop? **(Date it started and how or what caused it?)**:

_____

_____

Has your condition been getting: □ Better □Worse □ Staying the same

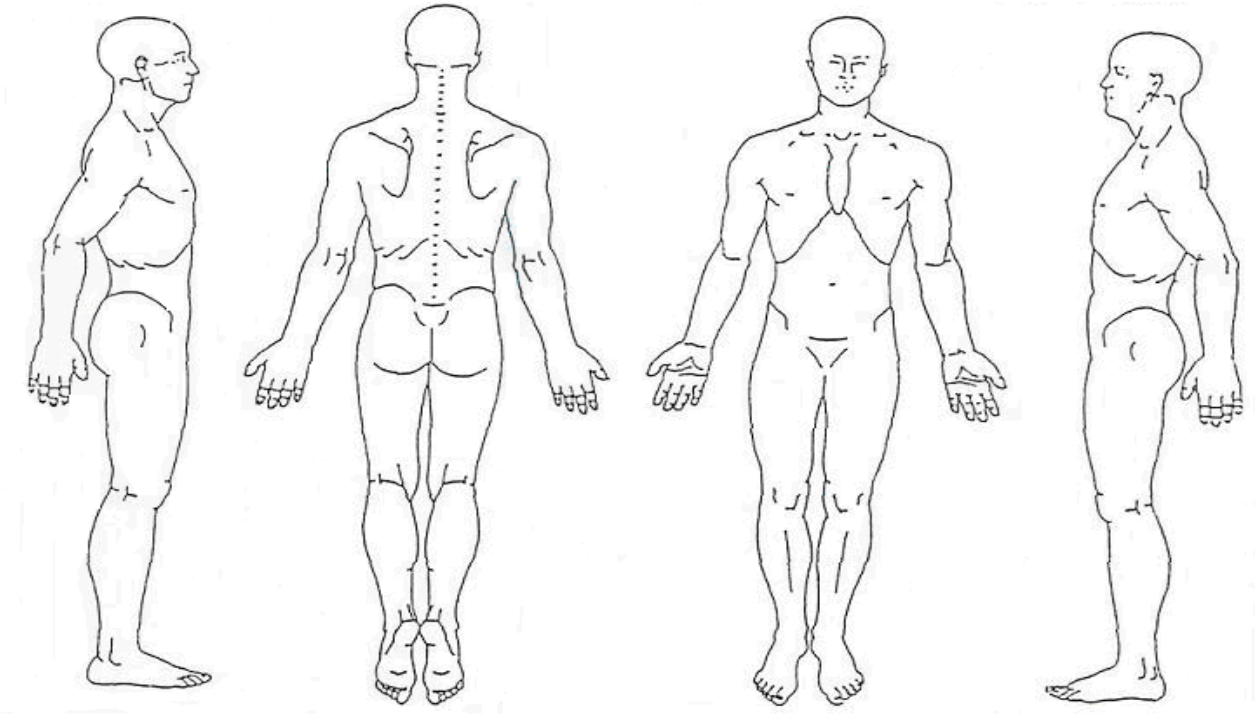
When is the pain worse, or what worsens it? _____

What improves your condition? _____

Have you received any treatment for THIS condition? □ YES □ No

If yes, with whom: _____

Please use the figures below to mark where your symptoms are located:



Please place one mark on the line below to indicate your present pain/symptom level.

NO Pain/symptoms |----------|**WORST Pain/Symptoms**

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS NOTICE.

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

_____

Patient (or guardian) signature