C H A T H A M
CHIROPRACTIC

Date ____________________

PATIENT INTAKE FORM

Name______________________________________ Male/Female DOB ____________________

SS# ______________________ (*required) Marital Status: S M D W

Email: _____________________________________ ***Used for appointment reminders**

Street Address _________________________________ Apt/PO Box ________________________

City _______________________________State ________ Zip code __________________________

Home Phone ______________________________ Cell Phone _______________________________

Work Phone ______________________________

Employer ______________________________ Occupation _________________________________

Emergency Contact____________________________ Relationship__________________________

Phone Number ______________________

Primary Physician____________________________ Physician Phone #_______________________

How did you hear about us? □ referred by a friend _________________________________

Internet Search □ PowerWorks Fitness □ Phonebook □ Facebook

□ www.ChathamChiropracticClinic.com

Are you covered by insurance? Yes or No

Circle One: Group Health Plan Medicare Auto Insurance Worker's Compensation

Primary Insurance Company _________________________________

Primary Policy Holder ______________________________________

Secondary Insurance Company _______________________________

Secondary Policy Holder_____________________________________

(Office use only)

DX: ______________, ______________, ______________, _____________

PATIENT HEALTH HISTORY FORM

When did incident occur? ____

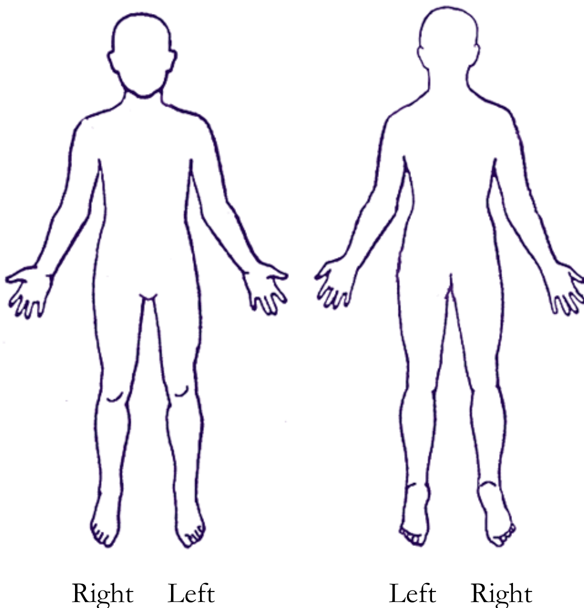
Where did incident occur? ____

How did the incident occur? ____

Type of Pain: __Stiffness __Burning __Numbness/Tingling __Sharp/Shooting __Aching

Time of day when symptoms are worse: __Morning __Afternoon __Evening

Mark Areas of Complaint on the figures below:



Circle pain level of each that apply:

Headache

0 1 2 3 4 5 6 7 8 9 10

Neck Pain

0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain

0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain

0 1 2 3 4 5 6 7 8 9 10

Low Back Pain

0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain

0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain

0 1 2 3 4 5 6 7 8 9 10

Other Pain :________________________________

0 1 2 3 4 5 6 7 8 9 10

Check if you have had or currently have any of the following:

□ Alcoholism □ Epilepsy □ Heart Disease □ Influenza □ Miscarriage

□ Multiple Sclerosis □ Mumps □ Pneumonia □ Stroke □ Anemia

□ Tuberculosis □ Eczema □ Appendicitis □ Thyroid Disease □ Arthritis

□ Ulcers □ Cancer □ Venereal Disease □ Cold Sores □ Dizziness

□ Diabetes □ Migraines □ Jaw pain □ Chest pain □ Lung problem

□ Heart problems □ Ankle swelling □ Cold extremities □ Blurred vision □ Vision problem

□ Allergies □ Fainting □ Poor appetite □ Difficulty breathing □ Depression

□ Confusion □ Constipation □ Dental problems □ frequent nausea □ Vomiting

□ Irritable bowel □ Stroke □ Liver problems □ Paralysis □ Fatigue

□ Loss of sleep □ Chemical Dependency

FINANCIAL POLICY FOR CHATHAM CHIROPRACTIC

Dr. J. Bryan Taylor, DC

Welcome to Chatham Chiropractic Clinic. Our goal is to provide our patients with the best possible care and to maintain a good physician-patient relationship. We believe that these objectives are best achieved when our patients are clearly informed of our financial policy. Please review this policy carefully. We encourage patients to review any questions with our staff.

Insurance Coverage

By receiving services from this office, you have created a legal obligation between you and this office, and you are agreeing to pay for our services. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic, even if this office is a participating provider in your insurance network. We are not responsible for your insurer's final benefit determination, and you are responsible to pay for any care that is determined to be non-covered, even after an initial verification of coverage.

As a courtesy to you, we will contact your insurer to inquire about your benefits. To assist us, please provide your insurance card prior to service. Insurance coverage for the services we provide varies from insurer to insurer and plan to plan. Most insurers provide an initial "verification" of coverage but do not guarantee that payment will be made.

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Billing and Payment

As a courtesy, we will submit bills to your insurer. **You will be responsible for payment of copayments, deductibles, and co-insurance amounts upon your arrival on the date of your visit.** This office accepts cash, checks and the following credit cards: Visa, MasterCard, Discover, and American Express.

In cases of separation, divorce or shared custody, any adult parent accompanying a minor child to an appointment is responsible for payment, regardless of the terms of the separation or divorce. It is the responsibility of family members, not this office, to resolve legal disputes, and terms of a divorce do not supersede the legal obligation for the accompanying parent to pay for our services.

Any remaining balances are due upon receipt of the billing statement. We will impose a **$20.00** fee for returned checks. **Any accounts not paid within 90 days of the statement date will be turned over for collection. You will be responsible for the entire cost incurred in our office plus an additional 30% for collections costs.**

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I understand and agree to all terms and conditions of this Financial Policy, including the provision that all health services rendered to me and charged to me are my personal financial responsibility.

Please initial each section and sign below.

____ ____________________

Signature of Patient or Responsible Party Date

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Printed Name of Patient or Responsible Party