PATIENT INTAKE

Legal Name _____ DOB _____

Sex Male/Female

Preferred Name _____

Address _____ Pronouns He/Him She/Her They/Them

_____ Marital Status S M D W # of children____

_____ Emergency Contact_____

Cell/Home #_____ Emergency Contact Phone_____

E-mail _____ Primary Care Physician_____

Occupation _____ Primary Care Physician City_____

Employer _____ Referred by_____

HEALTH INFORMATION

What is your major complaint? _____

Other complaints: _____

How long have you had this condition (approximate date)? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ❑ YES ❑ NO ❑ CONSTANT ❑ COME & GOES

Is this condition interfering with your: ❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER _____

How long has it been since you really felt good? _____

When was your last physical or doctor's appointment? _____

Other chiropractors, physical therapist or medical doctors who treated this condition: _____

List any allergies: _____

List any broken bones and surgical operations and when: _____

_____

Medications/Drugs you take:_____

Are you wearing orthotics/shoe inserts/heel lifts?_____

Have you been in an auto accident? When? Describe:_____

Medical History

Past Medical History

❑ Alcoholism
❑ Alzheimer's &/or Parkinson's
❑ Anemia
❑ Asthma
❑ Anxiety Disorder
❑ Arthritis
❑ Autoimmune disease
❑ AIDS/HIV
❑ Back/Posture Problems/Sciatica
❑ Bleeding Disorder
❑ Blood Disease
❑ Cancer
❑ Circulation Problems
❑ Diabetes
❑ Depression
❑ Ear or Eye Problems
❑ Eating Disorder
❑ Epilepsy
❑ Glaucoma
❑ Gout
❑ Heart Disease
❑ Heart Problems/Palpitations
❑Hepatitis – A, B, or C
❑ High Blood Pressure
❑ High Cholesterol
❑ Joint Disorder
❑ Kidney Disorder
❑ Light Headed/Dizzy
❑ Liver Disorder
❑ Lung Disease
❑ Migraine/Headaches
❑ Osteoporosis
❑ Pneumonia
❑ Rheumatic Fever
❑ Stroke
❑ Thyroid Disorder

Other: _____

Social History

Alcohol	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
Tobacco Products	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
OTC Stimulants	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
Caffeine	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
Drugs	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
Soft Drink	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
Exercise	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
Homemade Food	❑ Daily	❑ Weekly	❑ Occasionally	❑Never
Processed Food	❑ Daily	❑ Weekly	❑ Occasionally	❑Never

Other: _____

Family Medical History

❑ Alcoholism
❑ Alzheimer's &/or Parkinson's
❑ Anemia
❑ Asthma
❑ Anxiety Disorder
❑ Arthritis
❑ Autoimmune disease
❑ AIDS/HIV
❑ Back/Posture Problems/Sciatica
❑ Bleeding Disorder
❑ Blood Disease
❑ Cancer
❑ Circulation Problems
❑ Depression
❑ Diabetes
❑ Ear or Eye Problems
❑ Eating Disorder
❑ Epilepsy
❑ Glaucoma
❑ Gout
❑ Heart Disease
❑ Heart Problems/Palpitations
❑Hepatitis – A, B, or C
❑ High Blood Pressure
❑ High Cholesterol
❑ Joint Disorder
❑ Kidney Disorder
❑ Liver Disorder
❑ Lung Disease
❑ Measles
❑ Migraine/Headaches
❑ Osteoporosis
❑ Pneumonia
❑ Rheumatic Fever
❑ Stroke
❑ Thyroid Disorder

Other: _____

New Haven Chiropractic & Sports Rehabilitation

ASSIGNMENT/DIRECT PAYMENT TO DOCTOR
PRIVATE/GROUP ACCIDENT and HEALTH INSURANCE

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

New Haven Chiropractic & Sports Rehab
129 Church Street Suite 102
New Haven, CT 06510

If policy provisions prohibit direct payment to physician, I hereby also instruct and direct you to make out the check to me and mail to the address above. Payment is for the professional or medical expense benefits allowable, and otherwise payable, to me under my current insurance policy as payment toward the total charges for professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Agreement of Rights and Benefits shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

DATE Signature of Policy Holder

I understand that New Haven Chiropractic & Sports Rehabilitation has a cancellation policy of 24 hours prior to a scheduled appointment. I understand that if I fail to call to cancel or reschedule my appointment **twenty four** hours prior to my scheduled appointment or if I do not show up for my scheduled appointment there is a **$25.00** cancel short notice/no show fee. This fee will need to be paid in full before I can schedule any further appointments.

_____ _____

DATE Signature of Policy Holder

New Haven Chiropractic & Sports Rehabilitation LLC

129 Church Street Suite 102
New Haven, CT 06510
(203) 376-7726

HIPAA PRIVACY NOTICE
(effective 4/14/03)

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. In 1996, Congress as part of the (HIPAA) Health Insurance Portability and accountability Act, orders that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards, and even video rentals.
This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also for prescription to be called into your pharmacy and for scheduling of surgery in a hospital.

Additionally, none is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.

Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete or inaccurate. You have the right to review when and to whom your information was released. You may suggest additional restrictions with regard to certain issues and disclosures, if you wish. Portions of this notice may be modified, as long as you are notified. Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.

The law requires that you acknowledge receipt of this notice; this has been included on the signature release on your registration form.

Acknowledgement:

Patient name: _____

Signature: _____ Relationship to patient: _____ Date: _____

May we contact your primary care physician about your current or past health conditions?

❑ Yes ❑ No

Patient name: _____

Signature: _____ Relationship to patient: _____ Date: _____

New Haven Chiropractic & Sports Rehabilitation LLC

Gregory D. Hom, DC, ICCSP
129 Church Street Suite 102
New Haven, CT 06510
(203) 376-7726

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of consultation, evaluation, chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, dry needling, cupping, myofascial muscle work, and myofascial massage on me (or on the patient named below, for who I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office.

I further understand that such chiropractic services may be performed by the physicians of New Haven Chiropractic & Sports Rehabilitation LLC who may treat me now and in the future at this office. I have had the opportunity to discuss with the physicians the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks of treatment: including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of my treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date

To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated):

_____
Print Patient's Name

_____
Print Name of Representative

_____
Signature of Representative

This form should be maintained in the patient's health record.