Carone Chiropractic Center Initial Intake Form

Patient Name: _____ **Date:** _____

Address: _____

_____

Email: _____ **Home Phone:** _____

Cell Phone: _____ **Sex:** ☐ Male ☐ Female **Birth Date:** _____

☐ Married ☐Widowed ☐Single ☐ Minor ☐Separated ☐Divorced ☐Partnered for _____ years

Occupation: _____ **Employer:** _____

Emergency Contact: Name: _____ Relation: _____

Phone Number: _____

Primary Care Physician: Name: _____ Office: _____

Family History: Mother: _____

Father: _____

Sibling: _____

Referred By: _____

Financial Policy, Assignment of Benefits and Notice of Private Practices

To provide timely and accurate payments to Carone Chiropractic, PC for any services furnished the patient listed above by Carone Chiropractic, PC health care providers:

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I assign my right to receive payment of authorized benefits to Carone Chiropractic, PC.
- I request that payment of authorized benefits be made on my behalf to Carone Chiropractic, PC for any services furnished the patient listed above by Carone Chiropractic, PC health care providers.
- I authorize Carone Chiropractic, PC to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
- If my Health Insurance Plan will not direct payment to Carone Chiropractic, PC, I agree to forward to Carone Chiropractic, PC all health insurance payments which I receive for the services rendered by Carone Chiropractic, PC and its health care providers.
- I authorize Carone Chiropractic, PC or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I agree to pay all charges which are not covered by my Health Insurance Plan or which I am responsible for payment under my Health Insurance Plan.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Carone Chiropractic, PC.
- All fees are collected at the time of service. This includes any copays, coinsurance, or deductible amounts. In the case of insurance, once we receive the EOB (Explanation of Benefits) from your insurance company, we will address any discrepancies in the amount collected. For example, if you are required to meet a deductible before your insurance will pay, we will do our best to estimate your total responsibility. If the EOB indicates that the amount applied to your deductible is more or less than the amount paid at the time of service, we will either send you a bill or credit your account. Although we will do our best to communicate to you the terms of your policy, it is ultimately your responsibility to understand any limitations of your coverage.

I acknowledge that I have received Carone Chiropractic PC's Notice of Privacy Practices for protected health information.

_____ _____ _____

Signature of patient, parent, guardian, or personal representative Relationship to patient Date

Name: _____ Date: _____

NO	YES	
☐	☐	Do you have a past history of cancer?
☐	☐	Have you had any unexplained weight loss?
☐	☐	Does your pain fail to improve with rest?
☐	☐	Are you over 50 years old?
☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	Have you had spinal pain greater than 4 weeks?
☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	Intravenous drug use?
☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	Immunosuppression medication &/or condition?
☐	☐	History of significant trauma?
☐	☐	Minor trauma in person >50 years old?
☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	Are you over 70 years old?
☐	☐	Any history of prolonged use of corticosteroids?
☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)?
☐	☐	Loss of anal sphincter tone or fecal Incontinence (bowel accidents)?
☐	☐	Saddle anesthesia (numbness in the groin region)?
☐	☐	Global or progressive muscle weakness in the legs (legs give out) ?
☐	☐	Pregnant? Due date: _____

Medications:

_____
_____
_____

Surgeries:

_____
_____
_____

Social:

Tabaco use: _____
Alcohol: _____
Caffeine use: _____

Signature: _____

Current Health History

	Now	Past
GENERAL		
Fatigue	☐	☐
Weakness	☐	☐
Weight-loss	☐	☐
EARS	☐	☐
Hearing loss	☐	☐
Earache	☐	☐
Discharge	☐	☐
Ringing	☐	☐
THROAT		
Soreness	☐	☐
Swallowing	☐	☐
Infections	☐	☐
SKIN		
Rashes	☐	☐
Itching	☐	☐
Dryness	☐	☐
Mole Changes	☐	☐
Sores	☐	☐
CHEST		
Short Breath	☐	☐
Cough	☐	☐
Wheezing	☐	☐
HEART		
Cold Extremity	☐	☐
Ankle Edema	☐	☐
Murmur	☐	☐
Varicosity	☐	☐
Blood Clots	☐	☐
Palpitations	☐	☐
GENITALURINO		
Urine Hesitancy	☐	☐
Incontinence	☐	☐
Urgency	☐	☐
Frequency	☐	☐
Kidney Stones	☐	☐
WOMEN		
Painful Sex	☐	☐
Hot Flashes	☐	☐
Loss of Libido	☐	☐
BLOOD/LYMPH		
Bruising	☐	☐
Elev. Cholesterol	☐	☐
Elev. Triglycerides	☐	☐
Lymes Disease	☐	☐

	Now	Past
EYES		
Blurry	☐	☐
Double	☐	☐
Pain	☐	☐
Floaters	☐	☐
NOSE		
Bleeding	☐	☐
Loss of smell	☐	☐
Obstruction	☐	☐
Sinus Problem	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Dizziness	☐	☐
MOUTH		
Bad Breath	☐	☐
Bleeding Gums	☐	☐
Ulcers	☐	☐
Dental Problems	☐	☐
Loss of Taste	☐	☐
BREASTS		
Lumps	☐	☐
Pain	☐	☐
Discharge	☐	☐
GASTROINTESTINAL		
Abdominal pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody Stool	☐	☐
Black Stool	☐	☐
Jaundice	☐	☐
Heartburn	☐	☐
Hemorrhoids	☐	☐
Belching	☐	☐
Loss Appetite	☐	☐
MAN		
Loss of Libido	☐	☐
Impotence	☐	☐
Dribbling	☐	☐

_____

_____

Date: _____