BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

PATIENT INTAKE FORM - CHIROPRACTIC

Patient Name:_____ Birth Date (D/M/Y):____/___/_____

Age:_____ Gender: ☐Female ☐Male Email:_____

Address:_____ City:_____ Postal code:_____

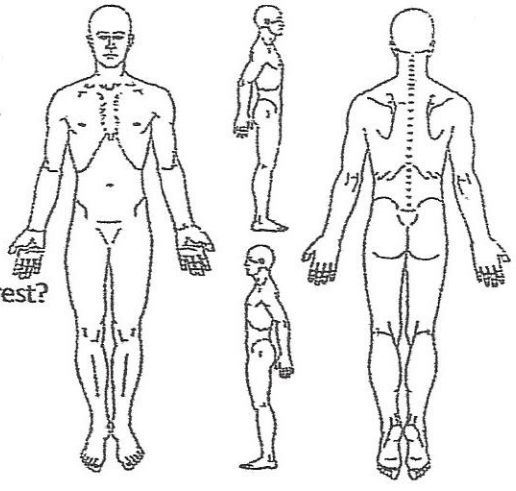
Phone (Home):_____ Phone (Cell):_____

Occupation:_____ Family Doctor:_____

How did you hear about our clinic? _____ Referred By: _____

Marital Status_____

Please mark where the pain is located.



1. What is your major symptom/problem?_____
2. When did your symptoms begin?_____
3. Have you had this problem before? ☐Yes ☐No
4. Is the problem there – ☐constant ☐comes & goes ☐with use ☐at rest?
5. Is the problem getting - ☐worse ☐no change ☐better?
6. What makes it worse?_____
7. What makes it better?_____
8. How does it feel? ☐Burning ☐Sharp ☐Shooting ☐Dull ☐Stiff ☐Aching ☐Tingling ☐Throbbing ☐Swelling Other:_____
9. How would you rate the sensitivity of your pain (0=no pain, 10=severe pain)? _____
10. Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation?
11. What test have you had for this condition?: ☐Spinal Exam ☐X – ray ☐MRI ☐CT Scan
12. Have you received any treatment for this condition? ☐Orthopedic ☐Physiotherapy ☐Massage Therapy ☐Acupuncture ☐Surgery (Date D/M/Y:_____) Other: _____

Patient Health Questionnaire

Please check ( ) if any of the following apply to you. Knowledge of these conditions may influence the type of treatment you receive.

☐Anxiety/depression
☐Arthritis
☐Asthma
☐Cancer
☐Chest Pain
☐Chronic fatigue
☐Cold hands/feet
☐Diabetes
☐Digestive problems
☐Dizziness/Vertigo
☐Epilepsy
☐Falls/Head injuries
☐Headaches
☐Heart Disease
☐Herniated Disk
☐High Blood Pressure
☐Jaw Pain/TMJ
☐Pacemaker
☐Osteoporosis
☐Pain –Neck
☐Pain – Mid Back
☐Pain- Arm/Elbow
☐Pain – Hand
☐Pain – Wrist
☐Pain – Shoulder
☐Pain – Ankle or Foot
☐Pain – Leg
☐Pain – Knee
☐Allergy
☐Scoliosis
☐Stroke
☐Swelling, Stiffness of Joints
☐Tinnitus (Ear Noises)
☐Hearing, Vision loss
☐Other_____

Medications/Supplements you currently take:_____

Are you pregnant?: ☐No ☐Yes How many weeks? _____

HAVE YOU EVER:

Had an accident (car,fall,sport,other)? ☐No ☐Yes, please describe:_____

Had an operation? ☐No ☐Yes, please describe:_____

Had a fracture? ☐ No ☐Yes, please describe:_____

Been hospitalized? ☐No ☐Yes, please describe:_____

FAMILY HISTORY: Have your grandparents, parents or siblings ever been diagnosed with any of the following?

- ☐ High Blood Pressure
- ☐ Heart Stroke
- ☐ Stroke
- ☐ Diabetes (Type I or Type II)
- ☐ Thyroid/ Hormone Problems
- ☐ Breathing or lung problem
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Neurological problems
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Other specifiy:_____

I certify that all the above personal health information, on page one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Print Patient Name:_____

Patient or Guardian Signature:_____ Date (D/M/Y) _____/_____/_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Social Security _____

SECTION B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a reversed Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Bentin Chiropractic Wellness Center
7545 W, Boynton Beach Blvd., Suite. 102
Boynton Beach, FL 33437

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

ACKNOWLEDGMENTS

1. *I instruct the chiropractor to deliver the care that, in his or her professional judgment can best help me in the restoration of my health, I understand that the care offered at Bentin Chiropractic is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct health art form from medicine and does not proclaim to cure any named disease or entity.*
2. *I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.*
3. *I grant permission to be called to confirm or reschedule an appointment and to be sent occasion cards, letters, email or health information as an extension of my care in the office.*

INSURANCE POLICY/FINANCIAL POLICY AND RELEASE OF AUTHORIZATION

Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify and file claims to your PRIMARY insurance only. Verification is not a guarantee of benefits or payment. Your insurance company will make the final determination of eligibility and subsequent payment.

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits be paid directly to Bentin Chiropratic. I agree that this authorization will cover all services rendered until I revoke the authorization. I understand that I am financially responsible for any charge not covered by this assignment.

Copayments are due at the time of service unless other written arrangements have bee approved. If unpaid balances are more than 60 days delinquent, you may be referred to a collection agency.

Returned Checks-There will be a $12 fee for any returned checks.

Patient or Responsible Party Signature_____

Date:_____