



CHIROPRACTIC PATIENT INTAKE FORM

PERSONAL INFORMATION

TITLE: MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS. <input type="checkbox"/> MS. <input type="checkbox"/> DR. <input type="checkbox"/>					DATE:		
FIRST NAME		INITIAL		LAST NAME			HEIGHT :
							WEIGHT:
ADDRESS			APT #		CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE:		CELLUAR TELEPHONE:		EMAIL ADDRESS:		OCCUPATION:	
BIRTH DATE DAY/MONTH/YEAR		SEX ASSIGNED AT BIRTH:		HOW DID YOU HEAR ABOUT US?			
IN CASE OF EMERGENCY							
CONTACT NAME					TELEPHONE		RELATIONSHIP

MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? YES NO

DOCTOR'S NAME		DOCTOR'S TELEPHONE NUMBER		LAST VISIT	
ADDRESS		SUITE	CITY	PROVINCE	POSTAL CODE
DO YOU HAVE ANY ALLERGIES		ARE YOU MAKING A CLAIM FOR 1) RECENT MOTOR VEHICLE ACCIDENT: <input type="checkbox"/> YES <input type="checkbox"/> NO			
		2) WORK RELATED INJURY/ACCIDENT(WSID) <input type="checkbox"/> YES <input type="checkbox"/> NO			

CHIROPRACTIC INFORMATION

REASON FOR SEEKING CHIROPRACTIC CARE TODAY?		HOW LONG HAVE YOU BEEN SUFFERING WITH THIS CONDITION?	
HAVE YOU SOUGHT TREATMENT FROM ANY OTHER HEALTH CARE PROFFESIONAL? <input type="checkbox"/> YES <input type="checkbox"/> NO			
TREATMENT RECIEVED			
HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES PLEASE COMPLETE THE FOLLOWING:	
CHIROPRACTOR'S NAME:		LAST VISIT:	
REASON FOR SEEKING CARE		RESULTS <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR	

HEALTH INSURANCE

DO YOU HAVE PRIVATE HEALTH INSURANCE THROUGH A MEDICAL PLAN? NO <input type="checkbox"/>			
<input type="checkbox"/> YES; MY OWN PLAN	<input type="checkbox"/> YES; MY SPOUSE'S PLAN	D.OB	<input type="checkbox"/> YES; MY PARENTS PLAN
D.O.B	COMPANY _____	COMPANY _____	COMPANY _____
PLAN/POLICY # _____	PLAN/POLICY # _____	PLAN/POLICY # _____	PLAN/POLICY # _____
ID/CER/EMP # _____	ID/CER/EMP # _____	ID/CER/EMP # _____	ID/CER/EMP # _____

Direct Billing Policy

We offer direct billing to select insurance companies for your health care provided at Family Chiropractic Centre. This is not a mandatory service but a **courtesy to our clients**. We will try to directly bill only to those companies that may allow for it and for those policies that will pay the health care provider directly. If your insurance company/policy does not pay the provider directly then we will issue you a receipt on payment for you to submit to insurance yourself.

Direct Billing Consent, Authorization and Acknowledgement

Consent to Collect and Exchange Personal Information: I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud/plan abuse. I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services provided at Family Chiropractic Centre. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment.

Print name

Signature

Date

Privacy Policy

Your health care provider is responsible for all personal information entrusted in writing, as well as all information pertaining to the client. For example, health history and on-going treatment forms. All written and verbal client information is kept private and confidential and cannot be discussed or released unless written consent is given by the client for this release of personal information or as governed by law. Files are stored on location by the owner and can only be accessed by staff.

Cancellation Policy

To better serve our clients **we require at least 24 hours notice for changes or cancellations**. If you cancel within 24 hrs or you completely miss your appointment without cancelling, you may be charged the full amount of the session.

Reason: If we have notice, we may be able to fill your time slot with another client. As a courtesy, we will email a day in advance to remind you of your appointment, if you have provided that contact information.

I understand the above Policies and I agree they are fair and reasonable.

Signature: _____

Date: _____