

Adult Intake Form

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Street Address: _____

City | State / Zip: _____

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

Work Phone: () _____ Email: _____

Birth Date: _____ Age: _____ Sex: M F

Who can we thank for referring you or how did you hear about our office?

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Preferred Name: _____ Phone: () _____

Relation: _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Deerfield Family Chiropractic?

When did this begin? (If applicable)

Are there any major injuries and/or surgeries we should know about?

Have you seen any other providers for this condition? (List all that apply)

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your level of commitment to yourself and your health?

1 2 3 4 5 6 7 8 9 10

HEALTH CONCERNS

- | | |
|---|---|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues |
| <input type="checkbox"/> Digestive Troubles | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Loss of Concentration |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Neck/Back Pain | <input type="checkbox"/> Stiffness/Flexibility |
| <input type="checkbox"/> Pain in Arms/Legs | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold Hands/Feet |

Explain any boxes checked above or add additional concerns:

Is there anything else regarding your current condition you feel the doctor should know?

MEDICATIONS

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Other |
| <input type="checkbox"/> Migraine/Headache | |

Explain any boxes checked above:

VITAMINS/SUPPLEMENTS

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Probiotics |
| <input type="checkbox"/> Vitamin D3 | <input type="checkbox"/> Other |
| <input type="checkbox"/> Fish Oil/Omega-3 | |

Explain any boxes checked above:

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- ❖ We urge our patients to follow the doctor’s recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- ❖ A \$25 fee will be charged to your account for any appointments missed without a 24-hour notice of cancellation. We require a credit or debit card on file due to this policy.
- ❖ I authorize Deerfield Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- ❖ In order to file your claims in a timely manner (if applicable), we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits. Should your insurance carrier determine that any or all our services are ineligible for payment, you will be billed directly for those services.
- ❖ This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
- ❖ Late payment for non-coverage, deductible, and co-payment will be subject to an 18% annual finance charge, which will be added monthly to your account.
- ❖ If you have any questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.

Patient Signature: _____ Date: _____

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures (therapeutic treatment, if necessary), by Dr. Elizabeth Eyles and her staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Deerfield Family Chiropractic personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Deerfield Family Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Deerfield Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Patient Signature: _____ Date: _____

CONSENT TO USE PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by DEERFIELD FAMILY CHIROPRACTIC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____ **Patient Initials**

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____