JangDhari Family Chiropractic
New Patient Intake Form

Name ____ Date ____________________________

Date of Birth _______________ Age _______________

Home Phone _______________ Cell Phone _______________

Email Address ____

Address ____ City ____________________

State __________ Zip Code __________

Occupation _______________________________ Employer ______________________________

Marital Status M S W D Spouse's Name ____

Spouse's Occupation _________________________ Spouse's Employer _______________________

Emergency Contact __________________________ Phone _________________________________

Do you have children? Yes No If yes, how many? ____

How did you find out about our office? ____

Name of Primary Insurance Company (We only bill claims for Medicare Part B, Auto Accidents or Worker's Compensation)

____

Name of Secondary or Supplemental Insurance Company (if applicable)

____

Primary Care Physician Name ___________________________ Phone ____________________

May we have your permission to update your primary care physician regarding your care at our office if necessary? Yes No

What brings you into our office today?

____

How long has this issue been going on?

____

Is this issue due to a work-related accident or an auto accident? Yes No

Have you had any major illnesses, falls or surgeries?

____

Are you currently pregnant? Please include information about past pregnancies or childbirth _________

____

Have you been treated for any health conditions by a physician in the last year? Yes No

If yes, describe ____

What medications are you currently taking? ____

Authorization and Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with my primary care physician and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information, we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information _____________

____

Patient's Signature ____ Date _______________

Guardian's Signature Authorizing Care ________________________ Date _______________