

Welcome!



NEW PATIENT INTAKE

Date: _____

Patient Data

First Name _____ Last Name _____ Birth Date ___/___/___ Age _____
Address _____ City _____ State _____ Zip _____
Phone (cell) _____ (home) _____ (work) _____
Preferred Phone: Cell Home Work Email _____

- I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:
____ Text Message to my cell phone: **Please list your cell phone carrier:** _____
- Your email will NOT be shared with any 3rd parties and is used for occasional office announcements and promotions.

Gender: Male Female Marital Status: _____ Name of significant other _____

How did you find us: Friend _____ Insurance Plan Website Google Other _____

Employer Data

Employer _____ Your Occupation _____

Brief description: _____

Your typical day: Sit at computer most of day Light manual labor Heavy manual labor Repeated motion

Emergency Contact Information

Name _____ Relationship to patient _____

Contact phone: _____ Alternative phone _____

Payment Information

Who is responsible for your bill? Self Spouse Other _____

Health Insurance Company _____ ID # _____ Group # _____

Policy Holder's Name _____ Birth Date ___/___/___ Relationship _____

FINANCIAL POLICY

I understand that insurance billing is a courtesy provided to me by Buckingham Chiropractic and I am always financially responsible for any charges not covered by health care benefits. I understand copays, co-insurance, and deductibles are due at the time of my visits as well as any prior balance I may owe. I understand that I assign benefit to be paid by my insurance company directly to the provider of services rendered to me. I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and / or supplies received.

Patient/Parent/Guardian Signature: _____ Date _____

Patient Name: _____ Date _____

Medical History

Medical conditions (circle all that apply to you):

Arthritis Cancer Diabetes Heart Disease Hypertension Psychiatric Illness Stroke High Cholesterol
 NONE Other _____

What medications are you taking? _____

What vitamins, minerals, herbs do you take? _____

What allergies do you have? _____

What previous surgeries have you had? _____

Previous accidents, slip/falls, sports injuries, fractures?

Family History (M=Mother, F=Father, GM=Grandmother, GF=Grandfather)

Arthritis Cancer Diabetes Heart Disease Hypertension Stroke Thyroid Other

Parent: ___ ___ ___ ___ ___ ___ ___ ___ ___

Sibling: ___ ___ ___ ___ ___ ___ ___ ___ ___

Habits	None	Light	Moderate	Severe	Habits	None	Light	Moderate	Severe
Alcohol	___	___	___	___	Tobacco	___	___	___	___
Coffee	___	___	___	___	Drugs	___	___	___	___

Review of Systems

Review of Systems

(Indicate if you have had conditions in the past or presently have the conditions)

Cardiovascular	Past	Present	Respiratory	Past	Present	Allergic/Immunologic	Past	Present
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing					
Pacemaker						Ear, Nose and Throat	Past	Present
Jaw Pain /TMJ			Eyes	Past	Present	Difficulty Swallowing		
Irregular Heartbeat			Glaucoma			Dizziness		
Swelling of legs			Double Vision			Hearing Loss		
			Blurred Vision			Sore Throat		
Genitourinary	Past	Present				Nosebleeds		
Kidney Disease			Psychiatric	Past	Present	Bleeding Gums		
Burning Urination			Depression			Sinus Infections		
Frequent Urination			Anxiety					
Blood in Urine			Stress			Gastrointestinal	Past	Present
Kidney Stones						Gall Bladder Problems		
Lower Side Pain			Endocrine	Past	Present	Bowel Problems		
			Thyroid			Constipation		
Neurologic	Past	Present	Diabetes			Liver Problems		
Stroke			Hair Loss			Ulcers		
Seizures			Menopausal			Diarrhea		
Head Injury			Menstrual			Nausea/Vomiting		
Brain Aneurysm						Bloody Stools		
Numbness			Hematologic	Past	Present	Poor Appetite		
Severe Headaches			Hepatitis					
Pinched Nerves			Blood Clots			Musculoskeletal	Past	Present
Parkinson's			Cancer			Arthritis		
Carpal Tunnel			Bruising			Joint Stiffness		
Vertigo			Bleeding			Muscle Weakness		

Patient Name: _____ **Date:** _____

HIPPA PRIVACY PRACTICES

Authorization for Release of Information

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only allow us to give information to family members indicated below.

I authorize Buckingham Chiropractic to release my medical and / or billing information to the following individual (s):

- 1. _____ **Relation to Patient:** _____
- 2. _____ **Relation to Patient:** _____

I acknowledge that I have read and / or have been given the opportunity to review Buckingham Chiropractic, PLLC's Notice of HIPAA Privacy Practices for protected Health Information.

Print Patient's Name _____

Patient/Parent/Guardian Signature: _____ Date: _____

INFORMED CONSENT

I have read [X] or have had read to me [] the explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient/Parent/Guardian Signature _____ Date: _____

FINANCIAL POLICY

Assignment & Release- By signing below, I authorize Buckingham Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Buckingham Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or the amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations.

By signing below, I give my consent for examination and the performances of any tests or procedures needed. I, the undersigned, understand and agree

Patient/Parent/Guardian Signature: _____ Date: _____

CONSENT TO TREAT MINOR

I _____ hereby authorize Dr. Michael Buckingham and whomever he may designate as chiropractic assistants to administer care as deemed necessary to my son/daughter, _____ (minor's name).

Patient/Parent/Guardian Signature: _____ Date: _____

OFFICE POLICIES

Re-exam Policy: If a patient has not been seen in our office for 90 days, they present with a new injury or area of complaint, or if insurance has changed, they will be subject to a re-examination and a subsequent re-exam charge.

Cell Phone Policy: To keep a relaxing environment, please silence your cell phones and all electronic devices while in the office and please step outside to make or receive phone calls.

No Show Policy

Due to the high demand of appointments and to be respectful of the chiropractic needs of all our patients please be courteous and call or text our office promptly if you are unable to attend an appointment, we always have patients on a cancellation list that need care. If you are unable to keep your scheduled appointment, we require 24-hour notice.

There will be a \$25.00 charge for every appointment missed without proper notification.

Patient/Parent/Guardian Signature: _____ Date: _____