Buckingham Chiropractic

Care Beyond Your Expectations

Patient Intake Form

Patient Information

Full Name _____ **Date:** _____
First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birthdate:** _____ Male: ____ Female: _____ **Marital Status:** _____

Social Security Number: _____ **Email** _____

Home Phone: _____ **Work Phone:** _____ **Cell/Other:** _____

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:** _____

Employer: _____ **Occupation:** _____

How did you hear about our office? _____

Primary Language Spoken_____ Race_____ Ethnicity_____

Emergency Contact Information

Spouse's Name: _____ **Spouse's Date of Birth:** _____

Emergency Contact: _____ **Emergency Contact Phone Number:** _____

Payment Information

Please have your insurance card and photo ID ready so they can be copied for the clinic's records.

Person Responsible for Payment: _____ Phone**:** _____

Do you have health insurance**?** □ Yes □ No Who is the policy holder? _____

Policy Holder's date of birth: _____

Financial Responsibility: I understand that insurance billing is a courtesy provided to me by Buckingham Chiropractic and I am at all times financially responsible for any charges no 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.

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:** _____

Consent for Treatment

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 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 any tests or procedures needed. I, the undersigned, understand and agree

If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Patient/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: In an effort 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 in order 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 charge for every appointment missed without proper notification.

I, the undersigned, understand and agree to the above and, in order to be accepted as a new patient in this office, agree to abide by these policies.
Signature_____ **Date** _____

Buckingham Chiropractic
Health Questionnaire

Patient Information

Patient Name _____ **Date of Birth** _____

Medical History

Describe your reason for today's visit: _____ **Date of Onset:** _____

Describe onset: acute chronic gradual **Cause:** Unknown Accident

Prior pain to this area: None On and off for years Years ago **Side**: left right bilateral

Describe your pain: (Circle one or more) Achy Burning Dull Sharp Stiff Throbbing

Description of Pain: Mild Moderate Severe **Pain level (1-10):** _____

Does the pain radiate to other areas? _____

When is your pain the worst? Morning As day progresses Afternoon Evening During the night No change

What exacerbates this condition? _____ **What alleviates symptoms?** _____

Do you have numbness? _____ **If so, where?** _____

Do you have spasms? _____ **If so, where?** _____

Do you have weakness? _____ **If so, where?** _____

Do you have limited range of motion? _____ **If so, where?** _____

Pain with movement? _____ **Where?** _____

History of Treatment

Primary Care Physician _____**Phone** _____

Have you seen another doctor for these symptoms? If yes, who? _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition

_____

List any surgeries or hospitalizations you have had complete with the month and year for each _____

_____

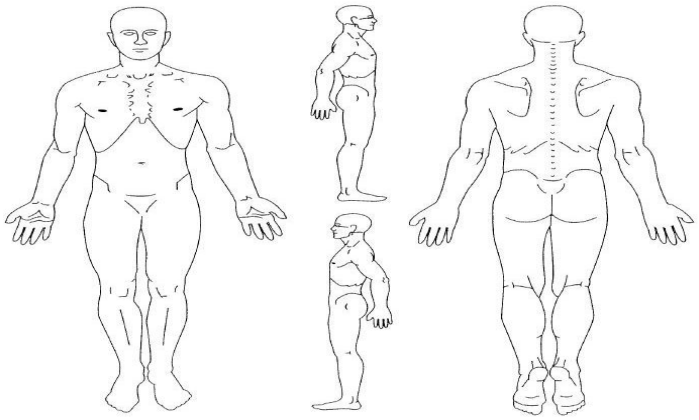
List any allergies _____

Family History (list all major diseases such as cancer, diabetes, heart problems, etc and the relation to you and the individual)

Do you smoke? □ Yes □ No **If yes, how many packs per day?** _____ **Are you pregnant?** □ Yes □ No

Description of Condition

Please circle the area (s) of discomfort:



Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

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						
Pace Maker								**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				Gout		
Carpal Tunnel				Bruising				Arthritis		
Vertigo				Bleeding				Joint Stiffness		
				Fever, Chills				Muscle Weakness		
Constitutional	Past	Present		Sweating				Osteoporosis		
Difficulty Sleeping								Broken Bones		
Weight Loss/Gain								Joints Replaced		

Patients Signature: _____ Date: _____