NEW PATIENT INTAKE

Name_____ Date_____/_____/_____ Date of Birth_____/_____/_____

Social Security Number_____ Sex: M F Pregnant: Y N Marital Status: S M D W

Address_____ City_____ State_____ Zip_____

Phone: Home (____)_____ Business (____)_____Cell (____)_____

E-mail_____ Occupation_____ Employer_____

Spouse: (Name_____ DOB ____/____/_____ Employer_____)

Past Chiropractic Care: Y N If Yes, When? _____ _____ Chiropractor's Name_____

Medical Doctor_____ Referring Doctor_____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Address: _____

If you were **referred** to Dr. Ross, we would like to thank them. Please provide their name: _____

Medical Insurance Information

Subscriber's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber's Date of Birth: _____ Relationship to Subscriber: _____

Are you now or have you ever been disabled? (Service or Work)? □ NO □ YES When? _____

Is your present condition due to an injury? □ NO □ YES | □ On the job □ Auto Accident □ Personal Injury □ Other_____

Accident Date: _____

Attorney Name: _____ Auto Insurance Carrier: _____

Have you sustained any **recent fractures** anywhere? Y N Describe: _____

List **all fractures** sustained previously:

Bone name or body area	Date	Bone name or body area	Date
1._____	_____	3._____	_____
2._____	_____	4._____	_____

If there is any additional information that you think would be relevant for us to ensure better personal healthcare quality, please include it in the following space.

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Authorization

- **PAYMENT IS EXPECTED AT TIME OF VISIT.** Are you insured? ☐ YES ☐ NO
  Company _____ Policy Holder's Name_____
  Date of Birth_____ Employer_____ ID #_____
- I authorize payments to Island Chiropractic Centre by my insurance company for all services rendered to me or to my dependants.
- I authorize the physician to release any information required for my chiropractic care or for insurance purposes as outlined in the Notice of Privacy Policies and Practices that is in the reception area for my viewing.
- I authorize use of this signature on all insurance submissions.
- I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Any amount authorized to be paid directly to Island Chiropractic Centre will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that I am responsible for payment for services rendered if my insurance company deems the provided services not medically necessary despite being clinically appropriate. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand that if I am accepted as a patient by the physicians of Island Chiropractic Centre, I am providing authorization for them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request and are outlined in the "Informed Consent to Treat" that I will receive. The doctor will not be responsible for any pre-existing medical conditions nor for any medical diagnosis.

Patient/Guardian Signature_____ **Date**_____

- DISCLOSURE POLICY FOR EDUCATION
  All digital photographs or x-rays taken of me may be reproduced for educational purposes. Island Chiropractic Centre has my authorization to use this information to educate current and future patients of the vitality of chiropractic care. I understand that this information will only be disclosed in an educational and anonymous form. I also understand that I, the patient, have the right to inspect the health information to be utilized. I understand that treatment will not be refused to me if I do not authorize the Disclosure Policy for Education. My consent will expire ten years subsequent to the date of signature. I have the right to revoke my consent in writing.

Patient/Guardian Signature_____ **Date**_____