Welcome to Billerica Chiropractic

NEW PATIENT INTAKE FORM

Print Name _____ **Today's Date** _____

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

Email Address _____ **Date of Birth**_____ **Male** ☐ **Female** ☐

Social Security # _____ **Single** ☐ **Married** ☐ **Spouse's Name:**_____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Occupation _____ **Employer** _____

If Minor: Mother's name _____ **Cell Phone #** _____

Father's name _____ **Cell Phone #** _____

Emergency Contact Name _____ **Phone #** _____

Have you had prior chiropractic care? No __ **Yes** __ **If yes, where:** _____ **When** _____

Who may we thank for referring you to our office? _____

Health History:

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

	Headaches		Pins and needes in legs		Fainting		Neck pain
	Pins and needles in arms		Loss of smell		Back pain		Loss of balance
	Dizziness		Buzzing in ears		Ringing in ears		Nervousness
	Numbness in fingers		Numbness in toes		Loss of taste		Stomach upset
	Fatigue		Depression		Irritability		Tension
	Sleeping problems		Neck stiff		Cold hands		Cold feet
	Diarrhea		Constipation		Fever		Hot flashes
	Cold sweats		Lights bother eyes		Problem urinating		Heartburn
	Mood swings		Menstrual pain		Menstrual irregularity		Ulcers

Do you have a Pacemaker? Y / N **Any history of Cancer Y / N** **Any metal implants? Y / N**

Reason for seeking chiropractic care:_____

Describe any health problems, including how long you've had them: _____

_____

Have you seen any other doctor for this problem? Yes❑ No❑ Name: _____

Name, Phone# & Address of PCP: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Billerica Chiropractic office will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name _____ **Signature** _____ **Date** _____

(If minor) I hereby authorize Billerica Chiropractic Office to evaluate and administer chiropractic care as deemed necessary to my child, _____. **Parent Signature** _____ **Date** _____

Billerica Chiropractic Office

Electronic Health Records Intake Form

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Current Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Heavy Tobacco Smoker / Light Tobacco Smoker Start Date: _____ # Years Smoked: _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage	Frequency	Start Date

Do you have any medication allergies? (List any other allergies if applicable.)

Medication Name	Reaction	Onset Date	Additional Comments

*Please note: Some of our patients have severe allergies. We ask that you kindly refrain from wearing perfumes or colognes when coming in for your appointment. Thank you for your understanding.

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____ Heart Rate: _____

☐ **I choose to decline receipt of my clinical summary after every visit**
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date:_____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
PRINTED

_____ _____
Signature Date

BILLERICA CHIROPRACTIC OFFICE, P.C.
Privacy Policy

THIS NOTICE DESCRIBES HOW CHIRORPACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Billerica Chiropractic Office we may use or disclose personal and health related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO a PPO or your employer, if they are or may be responsible for the payment of services provided to you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your recent care or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

If we provide health care services to you in an emergency.
If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to review this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.
You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Request to inspect copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Alesia, our office manager.

If you would like further information about our privacy policies and practices please contact Dr. Honi Kawut or Dr. Sanford Chapnick.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue, and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of April 15, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Printed Name Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient.

BILLERICA CHIROPRACTIC OFFICE, P.C.
PATIENT AUTHORIZATION RELEASES

Authorization For Appointment Reminders and Scheduling Related Matters: It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Billerica Chiropractic office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Printed Name Signature Date

Authorization For Thank You Cards, Birthday Cards, Welcome Letters and Newsletters: It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to thank you for referring someone to our office; to send you birthday wishes; or to send you our newsletter.

The use of this information is intended to further enhance the quality of your experience with our office. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Billerica Chiropractic Office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Printed Name Signature Date

Authorization For Contact Regarding Chiropractic Care, Related Health Services and/or Related Health Products: It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Billerica Chiropractic Office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Printed Name Signature Date

Any or all of the above authorizations may be revoked by you, at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.