GRAHAM
CHIROPRACTIC
CENTER, INC.
BRYAN GRAHAM, DC, CCSP

110 Long Pond Road, Suite 210 · Plymouth, MA 02360 · (508) 747-1434

New Patient Intake Form

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please fill out this form as completely as possible. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name_____ Date_____
First Middle Initial Last

Address _____ City _____ State ____ Zip _____

Sex: ❑ Female ❑ Male Birthdate _____ E-mail _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: ❑ Home ❑ Cell ❑ Work

Are you: ❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency _____ Phone (____) _____

Whom may we thank for you referring you to our office:_____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (____) _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ SSID# _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State ____ Zip _____

Insurance Co. _____ Phone (____) _____ Group # _____ Employer # _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ SSID# _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____ State ____ Zip _____

Insurance Co. _____ Phone (____) _____ Group # _____ Employer # _____

Symptoms

Reason for visit _____

When did you first noticed the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑Lying Down
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑Burning ❑ Tingling
❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other
Rate the severity of your pain. (1 is mild to 10 is severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What treatment have you already received for your condition?
❑Medication ❑ Surgery ❑ Physical Therapy ❑ Other _____
Name of the other doctor(s) who have treated you for your condition: _____

Health History

Check only those conditions which are applicable:

❑ AIDS/HIV	❑Cataracts	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑Alcoholism	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's	❑ Tonsilitis
❑ Allergy Shots	❑ Depression	❑Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anemia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors/Growths
❑ Anorexia	❑Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Appendicitis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Arthritis	❑ Fractures	❑Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Asthma	❑Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Venereal Disease
❑ Bleeding Disorder	❑ Goiter	❑ Miscarriage	❑ Rheumatic Fever	❑ Whooping Cough
❑ Breast Lump	❑ Gonorrhea	❑ Mononucleosis	❑ Scarlet Fever	❑ Other _____
❑ Bronchitis	❑ Gout	❑ Multiple Sclerosis	❑ Stroke	_____
❑ Bulimia	❑ Heart Disease	❑Mumps	❑ Substance Abuse	_____
❑Cancer	❑ Hepatitis	❑ Osteoporosis	❑Suicide Attempt	_____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control? ❑ Yes ❑ No
List any types of surgeries which you have had and the dates which they occurred: _____
_____

Do you have any replacement joints or other hardware: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy
What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

Do you smoke? ❑ Yes ❑ No How much per day? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever had a change in health.
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Graham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Graham may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

GRAHAM
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Name: _____ DOB: _____

Please list all current medications, vitamins, and supplements:

_____
_____
_____
_____
_____
_____
_____

Race:	**Marital Status:**
_____ American Indian or Alaska Native	_____ Single
_____ Asian	_____ Married
_____ Black or African American	_____ Divorced
_____ Native Hawaiian or other Pacific Island	_____ Widow/Widower
_____ White	
_____ I choose not to answer/identify	
	Ethnicity:
Smoking:	_____ Hispanic or Latino
_____ Yes How much? _____ packs/day	_____ Not Hispanic or Latino
_____ No	_____ I choose not to answer/identify

Allergies to medication: _____

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Informed Consent to Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnosis X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic name below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature Date

_____ _____

Patient Name Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient Signature Date

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Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointment. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed.

We regrettably must now charge a fee for all appointments that are not cancelled or rescheduled. We thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

_____ _____

Patient Signature Date

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NON-COVERED SERVICE WAIVER

Patient Name: _____

Patient Date of Birth: _____

Provider Name: _____

I, _____, understand that the services and/or supplies rendered to me may not be eligible for benefits (e.g. service may be determined to not be medically necessary, non-covered or investigated) by _____. I understand that my health insurance has certain restrictions and limitations, such as non-covered services and/or limited visits per year. Since I have chosen to receive the services, I agree to be financially responsible for any and all related charges that are not covered by my insurance.

_____ _____
Patient Signature Date

I, Bryan Graham, certify that I have informed my patient, _____, that _____ may not cover certain services under the members plan as they are considered non-covered services or there may be a limited number of visits per year.

_____
Provider Name

_____ _____
Provider Signature Date

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