

**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 _____

Address _____ City _____ State _____ Zip _____
First Middle Initial Last

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 # _____

"Chiropractic care for a balanced life"

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:

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

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Financial Agreement

Please read all areas as your status may change throughout your care plan.

Patients with Group or Individual Insurance

When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any co-payments or deductibles. Any services not covered by your insurance or remaining balances are your responsibility and will be billed to you after payment by your insurance is received. Co-payments are due at the time of service.

Patients with Medicare

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

Secondary Insurance

Please inform us of any secondary insurance you may have. For patients with Medicare your secondary insurance may pay for remaining fees.

“On the Job” Injury (Worker’s Compensation)

If you are injured on the job, your care should be paid for under your employer’s Worker’s Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 8 months, or if you suspend or terminate care, any fees and services are due immediately.

Personal Injury or Automobile Accidents

Please notify your auto insurance carrier of your visit to our office immediately. Notify us if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Cash Paying Patients

If you do not have insurance or if your insurance does not cover chiropractic care we provide payment options. Payment at time of service is preferred. Any outstanding balances will be billed to you. We accept cash, personal checks, and debit/credit cards.

I have read and understand the payment policy of Graham Chiropractic Center. I understand that my insurance is an arrangement between myself and my insurance company, not between Graham Chiropractic Center and my insurance company. I understand that if my insurance does not respond within 60 days, or if I suspend or terminate my scheduled care as prescribed by the doctors at Graham Chiropractic Center that fees will be due and payable immediately.

Patient's Signature (or guardian if a minor)

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

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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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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Name: _____ DOB: _____

Please list all current medications, vitamins, and supplements:

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

Allergies to medication: _____