261 Springfield Ave, Suite 202 ● Berkeley Heights, NJ 07922 ●Tel: 908-464-8899

Welcome to Smith Chiropractic. Please take a few minutes to share this important information with us regarding your health and the reason for your visit.

New Patient Intake Form

Date ______________________

First Name ____________________ **Middle Initial** ____ **Last Name** __________________

Prefers to be called ____________________

Address ____

City _________________________________ **State** _________________ **Zip Code** _______

Home Phone (_____) ________-___________ **Email** _________________________________

Cell Phone (_____) ________-___________ **Text message appointment reminder Y / N**

Date of Birth ______/______/_______ **Gender:** Male Female Other

Single Married Partnered Widowed Divorced Separated Minor

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer ____

Your Occupation ____

Name of Spouse ____________________________ **Preferred Phone** (_____) _____-______

Emergency Contact ____

Relationship to Patient ___________________ **Preferred Phone** (_____) _______-________

How did you hear about our office? ____

Reason for your visit to Smith Chiropractic today:

____

____

When did your symptoms appear? ____

Are your symptoms a result of an accident? Yes No Date: ____________________

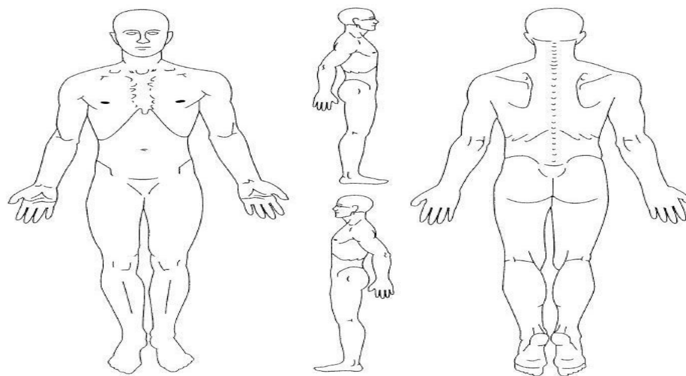
Type of accident: Motor Vehicle Work Related Home Other

Does it interfere with your Work Sleep Daily Routine Recreation Sports

Is the condition getting progressively worse? Yes No Unknown

Rate the severity of your pain Mild Moderate Severe

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N = Numbness B = Burning S = Sharp T = Tingling A = Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Is your condition worse: upon waking / morning / afternoon / positional / during sleep / as the day progresses / all the time?

What helps the condition? ____

What aggravates the condition? ____

What treatment have you received for the condition? Medications Surgery
Physical Therapy Chiropractic Care None Other _________________________

Name of other doctor/s who have treated you for your condition ______________________

____

What are your chiropractic care goals?
pain/symptom relief corrective care supportive care

HEALTH HISTORY

Date of last physical exam __________ **Name of primary care physician** ________________

Please list (or provide copy) of all current medications ________________________________

____

Please list all vitamins, herbs, or homeopathic remedies you take _______________________

____

Are You Pregnant? Yes No

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other ___________	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other ______________		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical ___________	Sulfites	Wheat/Glutens	Other _________

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>8 hours/night	Insomnia

Other ________________

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling	Hypertension	Parent	Sibling
Cancer:	Parent	Sibling	Stroke	Parent	Sibling
Diabetes:	Parent	Sibling	Thyroid	Parent	Sibling
Heart Disease	Parent	Sibling	Other _________________		

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper

Other ________________

Review of Systems – Check box if you have had trouble with any of the following

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			**Ear, Nose and Throat**		
High Cholesterol			Wheezing			Difficulty Swallowing		
Pacemaker			**Eyes**			Dizziness		
Jaw Pain			Glaucoma			Hearing Loss		
Irregular Heartbeat			Double Vision			Sore Throat		
Swelling of legs			Blurred Vision			Nosebleeds		
Genitourinary			**Psychiatric**			Bleeding Gums		
Kidney Disease			Depression			Sinus Infections		
Burning Urination			Anxiety			**Gastrointestinal**		
Frequent Urination			Stress			Gall Bladder Problems		
Blood in Urine			**Endocrine**			Bowel Problems		
Kidney Stones			Thyroid			Constipation		
Lower Side Pain			Diabetes			Liver Problems		
Neurologic			Hair Loss			Ulcers		
Stroke			Menopausal			Diarrhea		
Seizures			PMS			Nausea/Vomiting		
Head Injury			**Hematologic**			Bloody Stools		
Brain Aneurysm			Hepatitis			Poor Appetite		
Numbness			Blood Clots			**Musculoskeletal**		
Severe Headaches			Cancer			Gout		
Pinched Nerves			Bruising			Arthritis		
Parkinson's			Bleeding			Joint Stiffness		
Carpal Tunnel			Fever, Chills			Muscle Weakness		
Vertigo			Sweating			Osteoporosis		
Constitutional			Varicose Vein			Broken Bones		
Weight Loss/Gain						Joints Replaced		
Low Energy Level						Neck Pain		
Difficulty Sleeping						Low Back Pain		
						Upper Back Pain		

Doctor's Signature ________________________________

Patient Name ______________________________________ **Date** ________________

Smith Chiropractic
Family Care and Sports Injury Center

PAYMENT POLICY

Thank you for choosing **Smith Chiropractic Family Care and Sports Injury Center** as your chiropractic care provider. We are committed to providing you with high quality and affordable health care. Please see below for our payment policy. We will be happy to answer any questions you may have. Once you feel comfortable, please sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE/ Horizon Blue Cross Blue Shield. We are an in-network provider with Horizon Blue Cross Blue Shield insurance plans. While we make every effort to provide you with a summary of your insurance benefits, knowing your benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your chiropractic coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician. We are only able to provide a summary of your chiropractic benefits. Please note that if you are part of the OMNIA Health Plans, we are considered a Tier 2 provider.
2. INSURANCE/ all other insurance plans. We are considered an out-of-network provider for all insurance plans other than Horizon Blue Cross Blue Shield. We will submit claims for your visits directly with your insurance carrier, but payment in full is required at each visit. All coverage benefits will be sent directly to you by your carrier. Benefits for out-of-network providers often begin once a higher annual deductible is met. While we will make every effort to provide you with a summary of your insurance benefits, knowing your benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your out-of-network chiropractic coverage.
3. MEDICARE. We are considered a non-participating provider for Medicare. This does not affect your chiropractic coverage through Medicare, it only affects the way that payments are handled. Smith Chiropractic will collect payment in full at the time of each visit. We will file all appropriate visits through the Medicare system and any reimbursements for those visits, approved by Medicare, will be sent directly to you.
4. MEDICARE ADVANTAGE PLANS. Like private insurance, each Medicare Advantage Plan is customized for the recipient. Many Advantage plans require providers to be part of their own private networks in order for services to be covered. While we will make every effort to provide you with a summary of your benefits, it is your responsibility to know your plan and what it allows for before you come in for your appointment.
5. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
6. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
7. CONVERGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
8. WELLNESS MADE AFFORDABLE. Smith Chiropractic offers this cost sensitive, in-house plan to patients who might not have affordable chiropractic benefits through their insurance carrier. Details of this plan will be provided upon request to anyone interested in paying for their chiropractic care directly.
9. MISSED APPOINTMENTS. While we understand that schedules change, we ask that you make **every effort** to keep your scheduled appointments. Late cancels and 'no shows' do not allow us the opportunity to offer the appointment to another patient who might be waiting. We reserve the right to charge you for the missed visit. The charges will be your responsibility, billed directly to you and are not covered by insurance. **Please help us to serve you better by keeping your regular scheduled appointment**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

____________________________________ ____________________

Signature of patient or responsible party **Date**

PATIENT INSURANCE INFORMATION

Insurance Carrier ______________________________ Member ID# ________________________ Group # ______________

Subscriber's Name ______________________________ Date of Birth ______________________________

Relationship to the patient ______________________________

At this time, I have decided not to use insurance. I will enroll in Smith Chiropractic's in-house Wellness Made Affordable plan (agreement and details are found on a separate document).

CONSENT FOR PROFESSIONAL SERVICES AND NUTRITIONAL COUNSELING

I herby authorize Dr. Patrick Smith to perform chiropractic care (chiropractic adjustments and manipulative treatments) and other associated procedures: physical examination, tests, physiotherapy, x-rays when necessary or any other services that he deems necessary in my (or my child's) case.

During the course of your treatment Dr. Smith may provide nutritional guidance. This is provided to you in order to support your body, improve your overall health, or speed the healing process. The advice given is general in nature and is not intended to treat a specific disease or symptom.

Dr. Smith may recommend specific nutritional supplements. Nutritional supplements have been proven to be safe when taken as directed, yet there is a chance for an adverse reaction from any product. If you feel you are having a reaction to a recommended nutritional supplement, stop using the product until you can discuss the matter with Dr. Smith.

All medication changes need to be made by your medical physician (M.D.)

Patient's signature ____ Date ____________________________

Patient or guardian's signature ___________________________________ Date ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Smith Chiropractic Family Care and Sports Injury Center's Notice of Privacy Practices for protected health information.

Name of Patient ____ (please print)

Signature of Patient / Personal Representative ______________________________

Date ______________________________