QC Core Chiropractic Wellness Center

NEW PATIENT INTAKE

PATIENT INFORMATION

Date _____

Patient_____

Address_____

City_____State_____Zip_____

Sex: ◊ M ◊ F Age: _____DOB:_____

◊Single ◊Married ◊Divorced ◊Widowed ◊Separated

Patient SS# _____-_____-_____

Occupation: _____

Employer: _____

Spouse's Name: _____

Birthdate: _____ SS# _____-_____-_____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

_____

Name of Medical Doctor:

_____

Facility_____Ph_____

INSURANCE INFORMATION

Insurance Co. _____

Subscriber's Name _____

Relationship to Patient _____

Birth date _____ Group #_____

Is patient covered by additional insurance? ◊YES ◊NO

Insurance Co._____

Subscriber's Name _____

Relationship to Patient _____ ___

Birth date _____ Group #_____

I, the undersigned certify that I (or my dependent) have insurance coverage with the company listed above and assign directly to Dr. Picchiotti and Dr. Meyers 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____

Signature Relation to Pt. Date

PHONE NUMBERS

Home _____Cell_____

Email_____

Best time/place to contact you ◊AM ◊PM ◊Home ◊Cell

In case of emergency, contact:

Name_____Phone_____

ACCIDENT INFORMATION

Is condition due to an accident? ◊ YES Date_____ ◊ NO

Type of accident ◊AUTO ◊WORK ◊HOME ◊OTHER

Has accident been reported to ◊Auto Insurance

◊Employer ◊Workers Comp ◊Other

Attorney/Contact_____

PRIMARY COMPLAINT

If you have more than one current complaint, please ask for an additional form.

Reason for visit _____

When did symptoms appear? _____

Is condition getting progressively worse? ◊ YES ◊NO ◊Unknown

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe) _____

Please mark on picture at right to show where your discomfort is.

Type of pain: ◊Sharp ◊Dull ◊Throbbing ◊Numbness ◊Other_____

Time of day it is worse ◊AM ◊PM What % of day in pain _____

Does it interfere with ◊Work ◊Sleep ◊Recreation ◊Daily Routine_____

Is there anything you do that relieves the pain? _____

What makes the symptoms worse? _____