



**PALM BEACH
FAMILY CHIROPRACTIC
& SPORTS MEDICINE**

General Patient Intake Form

File Number (Office Use) _____

Patient Information:

Today's Date _____

Home Phone _____

Name _____

Cell Phone _____

I prefer to be called _____

Work Phone _____

Address _____

Email _____

Social Security No. _____

Date of Birth _____ Age _____

Sex Male Female

Height ____' ____" Weight ____ lbs

Occupation _____

Marital Status _____

Employer _____

No of Children _____

Address _____

If minor, name of parent or guardian _____

Who should we contact in case of an emergency? _____

Relation _____

Phone _____

Address _____

Primary Care Physician _____

Phone _____

How did you hear about our office? _____

Have you ever been to a chiropractor before? YES NO If so, whom? _____

Insurance Information:

If you choose to use health insurance to help offset your financial responsibility, please give your card to the front desk for verification of benefits.

Reason for Visit:

1. This visit is as a result of (*Please circle*): **wellness, sports, auto, trauma, or chronic condition**

2. If this visit is for wellness visit or spinal checkup please skip questions 3 through 10.

3. If this visit is due to pain, when did the symptoms begin? ____ / ____ / ____

4. Please explain what you are experiencing. _____

5. Is the condition getting worse? YES NO CONSTANT COMES & GOES

6. List activities that aggravate the condition: _____

7. List activities that are inhibited because of the condition.

8. Have you had this or a similar condition in the past? YES NO

9. Have you been treated by a medical physician for this condition? YES NO

10. Are you taking any medication for this condition? YES NO If yes, please list: _____

(please complete side 2 of form)



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11. Are you suffering from any diseases or other conditions? If so, please describe below.

12. Please list previous surgeries/treatments with relation to your spine or condition.

13. Do you take supplements or vitamins? YES NO

14. Do you exercise? YES NO

15. Do you smoke? YES NO How much? _____ How long? _____

For women only: Are you taking birth control? YES NO

Are you pregnant or suspect you may be pregnant? YES NO

Are you nursing? YES NO

The following are Palm Beach Family Chiropractic & Sports Medicine's office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.

Consent for Treatment. I, the undersigned, give Palm Beach Family Chiropractic & Sports Medicine my permission to evaluate and treat my injury. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment.

Appointment Scheduling. Kindly give 24 hours notice if you are unable to keep a scheduled appointment. We reserve the right to charge \$25 for missed appointments without prior notice.

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. In the rare event it is necessary to send your account to collections and/ or an attorney for collections, you agree for it to be handled in Palm Beach County in the State of Florida, and to pay for any attorney fees that may be necessary.

Patient/Parent or Legal Guardian Signature _____ **Date** _____



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Assignment of Insurance Benefits

Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Palm Beach Family Chiropractic & Sports Medicine, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Palm Beach Family Chiropractic & Sports Medicine.

Furthermore, I hereby IRREVOCABLY ASSIGN to Palm Beach Family Chiropractic & Sports Medicine, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida statutes for any service and or charges provided by Palm Beach Family Chiropractic & Sports Medicine.

Signature of witness: _____

Signature of patient or responsible party: _____



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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____ have read a copy of **Palm Beach Family Chiropractic & Sports Medicine's** notice of Patient Privacy Practices.
Patient Name

Signature of patient or parent or legal guardian

Date