Elemental Chiropractic
1640 Old Apex Road
Cary, NC 27513

Elemental Chiropractic Patient Intake Form

Patient Name _____Date_____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____-_____ Date of Birth _____/_____/_____

Email _____

Sex: M F How did you hear about our office? _____

HEALTH HISTORY

Surgeries: _____
_____

Medical Conditions: _____
_____

Injuries/Hospitalizations: _____
_____

Family History: (Mark all that apply)

Arthritis:	___Parent	___Sibling
Cancer:	___Parent	___Sibling
Diabetes:	___Parent	___Sibling
Heart Disease	___Parent	___Sibling
Hypertension	___Parent	___Sibling
Stroke	___Parent	___Sibling
Thyroid	___Parent	___Sibling

In the Last 6 Months: (mark all that apply)
___Fatigue for unknown reasons
___Drastic Weight loss/gain
___Change in appetite/thirst
___Fevers/Chills/Sweats
___Pain that doesn't change with position
___Pain that wakes you up at night
___Bruising/Bleeding easily

Please list all current medications/Supplements being taken _____
_____

Do you experience headaches? (circle) Yes No
If so, please describe how often and how severe_____
_____

Have you ever been to a chiropractor before? (circle) Yes No
If so, when and for what?_____

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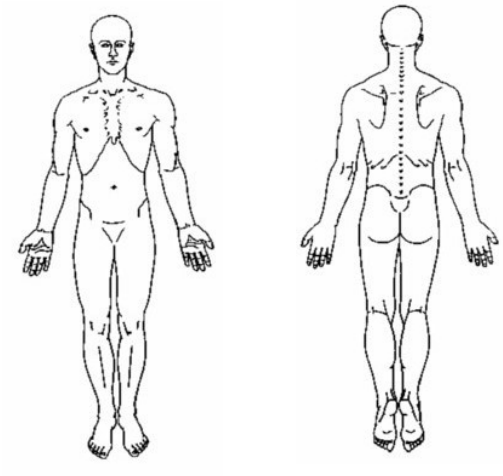
CURRENT COMPLAINT

Where is your pain? _____

Indicate on the body diagram where you are experiencing the following symptoms:



Average Pain Intensity: (please circle)

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

How did your symptoms begin?

_____

How long have you had your symptoms? _____

How often do you experience your symptoms? (Circle)

Constantly (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What describes the nature of your symptoms?

___Sharp ___Dull Ache ___Numb ___Shooting
___Burning ___Tingling ___Throbbing

Does your pain radiate? If yes, where? _____

Activities of Daily Living - Please check if you have pain or difficulty performing the following:

□ Change of Position □ Driving □ Extended Computer Use □ Stairs
□ Bending □ Walking □ Exercising □ Sleep
□ Sitting □ Standing □ Housework □ Work
Other_____

My pain/symptoms have previously been made better by: (Check all that apply)

□ Chiropractic □ Physical Therapy □ Massage □ Advil/Tylenol □ Heat □ Ice
□ Rest □ OTC Pain Meds □ Exercise □ Stretching □ Nothing improves my symptoms
□ Other: _____

I would be interested in:

___Chiropractic Care ___ Cupping
___ Supplement/Vitamin Suggestions ___ Sauna

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PAYMENT POLICY

Thank you for choosing Elemental Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your 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 prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. 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 us in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. 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.
5. COVERAGE 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.
6. MISSED APPOINTMENT. Our policy is to charge $25.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. 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