CAM Center of Hagerstown
Dr. Marc M. Gamerman
89 West Lee Street
Hagerstown, MD 21740
Phone 301-797-3737 Fax 301-302-7802

PATIENT INTAKE FORM

DATE: _____

NAME: _____
Last First Middle

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

EMAIL: _____

PREFERRED CONTACT PHONE #: _____ SECONDARY PHONE #:_____

DATE OF BIRTH: _____ AGE: _____ GENDER (Please circle): M / F LAST 4 OF SSN.:_____

YOUR OCCUPATION: _____EMPLOYER:_____PHONE:_____

MARITAL STATUS: M S W D NAME OF SPOUSE: _____ NUMBER OF CHILDREN: _____

IN CASE OF EMERGENCY CONTACT NAME: _____PHONE: _____

NAME OF PARENT/GUARDIAN (if patient is a minor):_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? _____ DOCTOR'S NAME: _____

PURPOSE OF THIS APPOINTMENT: _____

PAYMENT METHOD: (Please Circle) Self Pay Health Insurance Personal Injury Protection Workers Compensation

IS THIS CONDITION DUE TO: AUTO ACCIDENT _____ WORK INJURY_____ OTHER_____ DATE: _____

IF THIS IS A RESULT OF ONE OF THE ABOVE, DO YOU HAVE A LAWYER? _____ YES_____NO

LAWYER'S NAME: _____PHONE: _____

ADDRESS: _____CITY: _____STATE: _____ZIP: _____

PRIMARY CARE DOCTOR: _____DATE LAST SEEN/REASON: _____

X_____
Patient Signature

Flip Over→→→→→→→→→→

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CONSENT FOR TREATMENT: THE UNDERSIGNED CONSENTS TO THE TREATMENT AND THE PROCEDURES, WHICH MAY BE PERFORMED, DURING THE RECOMMENDED CHIROPRACTIC CARE.

RIGHT TO REFUSE TREATMENT: THE UNDERSIGNED UNDERSTANDS THAT HE/SHE HAS THE RIGHT TO MAKE AN INFORMED REFUSAL OF ANY TREATMENT THAT MAY BE CONSIDERED DURING OUTPATIENT CARE.

FINANCIAL RESPONSIBILITY: THE UNDERSIGNED AGREES, WHETHER HE/SHE SIGNS AS PATIENT, THAT IN CONSIDERATION FOR THE SERVICES TO BE RENDERED TO THE PATIENT HE/SHE HEREBY INDIVIDUALLY OBLIGATES HIMSELF/HERSELF TO PAY THE ACCOUNT OF DR. GAMERMAN, IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OF DR. GAMERMAN. THE UNDERSIGNED AGREES THAT IN THE EVENT THEIR INSURANCE DOES NOT PAY, THEY ARE RESPONSIBLE. IN ADDITION, IF THE ACCOUNT GOES PAST DUE OVER 90 DAYS, THE PATIENT ACCEPTS THAT THE LIABILITY CAN BE SENT TO COLLECTIONS AND 25% COLLECTIONS FEE MAY APPLY.

RELEASE OF INFORMATION: THE UNDERSIGNED DOES HEREBY AUTHORIZE DR. GAMERMAN TO RELEASE ANY AND ALL INFORMATION REGARDING THE PATIENT'S MEDICAL HISTORY AND TREATMENT ADMINISTERED DURING OUTPATIENT TREATMENT, TO ANY PHYSICIAN OR HOSPITAL OR TO ANY INSURANCE COMPANY, EMPLOYER, LEGAL COUNSEL OR OTHER ORGANIZATION RESPONSIBLE FOR THE PAYMENT OF THE PATIENT'S MEDICAL EXPENSES. IF THE PATIENT IS COVERED BY MEDICARE, THE UNDERSIGNED AUTHORIZES ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT THE PATIENT TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. THE UNDERSIGNED CONSENTS TO ALLOW MESSAGES TO BE LEFT ON THE PERSONAL PHONE NUMBERS PROVIDED BY THE PATIENT ON THE INTAKE FORM REGARDING FUTURE APPOINTMENTS. THE PATIENT ALSO AUTHORIZES DR. GAMERMAN TO OBTAIN MEDICAL RECORDS FROM OTHER HEALTHCARE PROVIDERS PREVIOUSLY SEEN.

ASSIGNMENT OF INSURANCE BENEFITS: THE UNDERSIGNED AUTHORIZES, WHERE HE/SHE AS AGENT OR AS PATIENT, DIRECT PAYMENT TO DR. GAMERMAN OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO OR ON BEHALF OF THE UNDERSIGNED FOR CHIROPRACTIC SERVICES. IT IS THE UNDERSIGNED'S RESPONSIBILITY TO SUPPLY THE OFFICE WITH A REFERRAL IF REQUIRED BY HIS/HER INSURANCE AND IF NOT SUPPLIED THE UNDERSIGNED WILL BE RESPONSIBLE FOR PAYMENT. IT IS UNDERSTOOD BY THE UNDERSIGNED THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: THE UNDERSIGNED HAS REVIEWED A COPY OF DR. GAMERMAN'S NOTICE OF PRIVACY PRACTICES AND A COPY WAS PROVIDED TO ME, IF I REQUESTED IT.

BY SIGNING THIS FORM, I ADMIT THAT THE CONTENTS OF THIS FORM HAVE BEEN FULLY EXPLAINED TO ME AND I DO UNDERSTAND THE CONTENTS OF THIS FORM.

SIGNATURE (PATIENT, PARENT, or GUARDIAN) X_____DATE_____

Relationship (circle one): Self Parent Guardian

PRINT PATIENT NAME _____ DATE OF BIRTH _____

PATIENT PAIN DRAWING

Dr. Marc M. Gamerman
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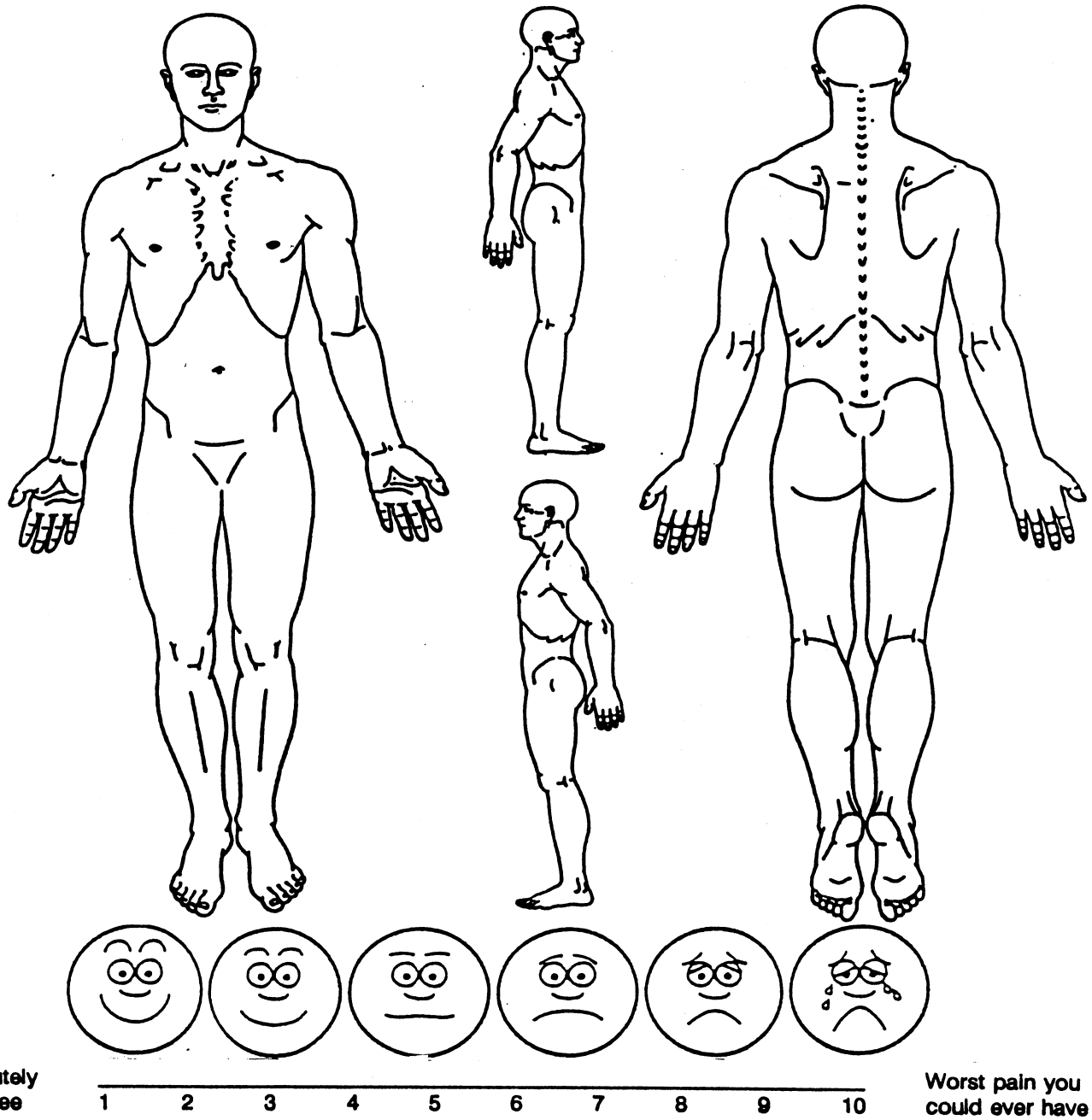
NAME: _____ DATE: _____

DATE OF BIRTH: _____

Mark the areas of complaints on the diagram using the following symbols. Also, use the scale below to indicate the pain level of your complaint(s).

Symbols:	Aching/Dull	Numbness	Pins & Needles	Burning	Stabbing	Other
	+ + + + + +	_____	**ooooooooooo**	**xxxxxxx**	/ / / / / / /	******



Absolutely pain free — 1 2 3 4 5 6 7 8 9 10 — Worst pain you could ever have

X_____

Patient Signature