Kilkenny Chiropractic

New Patient Intake

Name: _____ Today's date: _____

Date of birth: _____ Gender: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

*Please circle your preferred phone for communications from our office.

Married: yes no Spouse's name: _____ Children yes no Ages: _____

Occupation: _____ Full-time Part-time Retired Unemployed

Employer: _____

Student: Full-time Part-time School/Major: _____

Insurance: _____ Insured's Name: _____

Insured's date of birth: _____ Relationship to insured: _____

Insured's address (if different from the patient's): _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Last seen (month/year): _____

How did you hear about our office? _____

Have you seen a chiropractor before? yes no Comments: _____

_____

Patient Name: _____ Today's date: _____

Date your symptoms began: _____ Briefly describe your symptoms: _____

_____

How did your symptoms begin? _____

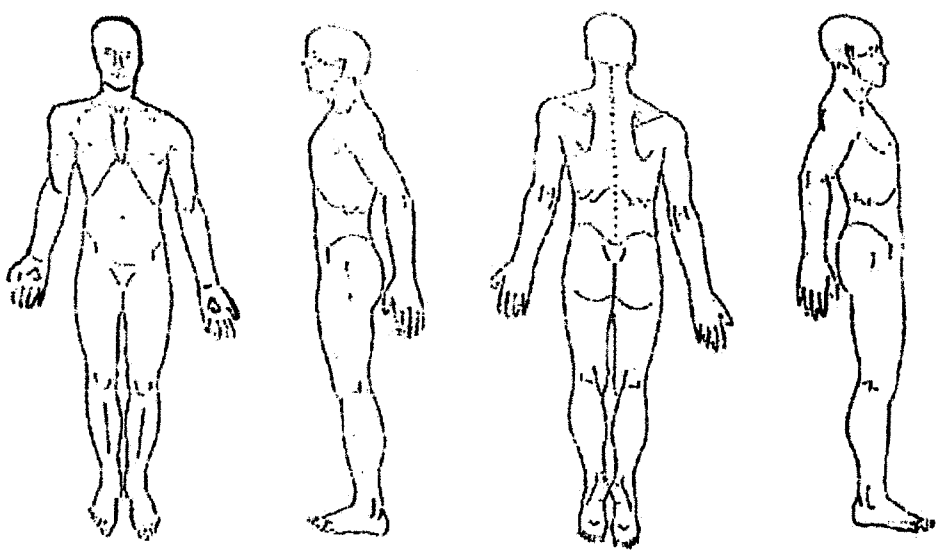
_____

Circle all that apply to your pain: Sharp Stabbing Shooting Dull Achy Numb Tingling

Rate your pain:

No pain	Mild pain	Moderate pain	Severe pain	Very Severe pain	Worst possible pain
0 1 2	3 4	5 6	7	8	9 10

Please mark all areas where you have pain



Health History Information Sheet

Patient Name: _____ Today's date: _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____lbs.

Past Medical History: Please mark <u>all</u> that apply to ***you*** with a "C" (current) or "P" (past).

	High Blood Pressure		Stroke/TIA		Diabetes Type I or II		Osteopenia/porosis
	Heart Condition		DVT/blood clots		Dizziness/Vertigo		Migraines or headaches
	High Cholesterol		Pulmonary Embolus		Fatigue/low energy		Circulatory Condition
	Kidney Disease		HIV/AIDS		Thyroid Condition		Arthritis
	Autoimmune Disease		Seasonal Allergies		Reflux/GERD		IBS/UC
	Hepatitis Type ____		Anxiety/PTSD		Depression		Epilepsy/Seizures
	Neurological Disease		Fibromyalgia		Tinnitus/hearing issues		Visual problems
	Respiratory Condition		Nausea/vomiting		Peripheral Neuropathy		Skin Condition
	Unexplained weight loss		Hair loss		Loss of smell/taste		Urinary Issues
	Reproductive Issues		Concussions # ____		Domestic Abuse		Cancer

Other: _____

Please explain positive responses above: _____

_____

_____

Live alone: yes no Tobacco Use: Never/In the past/Presently How much: _____ How long: _____

Alcohol use: Daily/Occasionally/None Other substance use or abuse: yes no _____

Current Medications/supplements: _____

ANY serious traumas/MVA/illnesses: _____

ANY surgeries/allergies: _____

Family Medical History: Please mark <u>all</u> that apply to your ***immediate family*** only.

	High Blood Pressure		Stroke/TIA		Diabetes Type I or II		Osteopenia/porosis
	Heart Condition		DVT/blood clots		Dizziness/Vertigo		Migraines or headaches
	High Cholesterol		Pulmonary Embolus		Fatigue/low energy		Circulatory Condition
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	Autoimmune Disease		Seasonal Allergies		Reflux/GERD		IBS/UC
	Hepatitis Type ____		Anxiety/PTSD		Depression		Epilepsy/Seizures
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	Unexplained weight loss		Hair loss		Loss of smell/taste		Urinary Issues
	Reproductive Issues		Concussions # ____		Domestic Abuse		Cancer

Other: _____

Please explain positive responses above: _____

_____

Patient Name: _____ Today's date: _____

I hereby attest that the above information is true and accurate to the best of my knowledge. I hereby authorize the doctor or her representative to examine and treat me for my injuries/symptoms and related illnesses as they deem appropriate. **I understand that fees for professional services from Kilkenny Chiropractic, LLC are due and payable at the time of the visit,** unless other arrangements have been made. I understand that copies of my office records are available and may be obtained by filling out and signing the appropriate medical release form, and that there may be a fee for this service, not to exceed the usual and customary rates.

I understand and agree that health insurance and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that as a courtesy, Kilkenny Chiropractic, LLC will assist me in submitting my bills to the insurance carrier and in making collections from the insurance company, and that any amount authorized to be paid directly to Kilkenny Chiropractic, LLC will be credited to my account upon receipt. However, **by affixing my signature below, I agree that I am personally responsible for full payment of all goods and services rendered me through this clinic**, regardless of the type and amount of insurance reimbursement provided for these services from third party payors.

_____ _____

Patient's printed name Today's date

_____ _____

Patient's signature Signature of parent/guardian for minor

Kilkenny Chiropractic, LLC
3592 Aloma Avenue Suite 3
Winter Park, FL 32792
407-706-1420

Doctors of chiropractic, medical doctors, osteopathic physicians, and physical therapists using manual therapy treatments for patients with neck problems are required to explain that there have been rare cases of imjury to a vetebral artery as a result of treatment. Such an injury has been known to cause stroke, sometimes with serious neurological injury. The chances of this happening are extremely remote, approximately 1 per 1 million treatments. Appropriate tests will be performed on you to help identify if you may be susceptible to that kind of injury. If you have any comments or questions about this, please speak with Dr. Whooley.

I have read and understood the above statement, accept the mentioned risk, and hereby consent to treatment.

Signature: _____ Date: _____

Witness: _____ Date: _____

Notice to all Patients

Welcome to our facility and practice! The following is important information regarding our patient policies. These policies aid us in ensuring proper care and customer services. If you have any questions or concerns, please do not hesitate in contacting our staff.

- Please sign in upon entering the facility for your scheduled appointment and check out with our receptionist prior to leaving. Please inform staff if your insurance, address or any other pertinent information changes.

- Payments are due at the time services are rendered unless prior arrangements have been made. Please be prepared to pay by credit card, check, or cash each office visit if necessary. **We will bill your insurance as a courtesy, but it is your responsibility to follow up on all insurance issues**. The billing department will do everything that can be done to resolve insurance issues, but it is your responsibility in the end.

- In order to provide all of our patients with proper care, it is imperative you arrive on-time for your scheduled appointment. It is imperative that you call if you are running late for your appointment, even being 5 minutes late may delay, shorten, or possibly cancel your appointment.

- **Failure to notify the clinic of cancellation of your scheduled massage therapy appointment at least 24 hours in advance will result in a $25 charge billed personally to you**. Your insurance company will NOT cover this fee.

- We value your time. If you have a limited amount of time for your session, please let us know in advance and we will accommodate you as best as we can.

Thank you for your patience and cooperation. By signing below, you certify that you agree to and understand the patient policies listed above.

Patient Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By completing the lines below, I _____ authorize being contacted for practice reminders, information, and changes by:

Email at: _____

Phone call at: _____ 2nd number: _____

Permission to leave a voice message? Yes No Permission to send a text message? Yes No

_____ _____

Patient's printed name Date

_____ _____

Patient's signature Parent/guardian if for a minor

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX (6) YEARS.

List below the names and relationships of people to whom you authorize Kilkenny Chiropractic, LLC to release Protected Health Information (PHI). This allows us to acknowledge that you are being treated here, discussion of your condition, and/or allow them to pick up records on your behalf.

_____ _____

_____ _____