

## Hubertus Chiropractic Center Intake Form

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male Female

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other \_\_\_\_\_

**Employer Data** \_\_\_\_\_

Employer \_\_\_\_\_

Your Occupation \_\_\_\_\_

**Spouse Data** \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Spouse Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Emergency Contact** \_\_\_\_\_

Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Contact Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**Medical Conditions:** (Circle all that apply to you)

- |              |                     |               |               |
|--------------|---------------------|---------------|---------------|
| Arthritis    | Cancer              | Diabetes      | Heart Disease |
| Hypertension | Psychiatric Illness | Skin Disorder | Stroke        |
| Other _____  | Fibromyalgia        | Asthma        | Osteoporosis  |

**Surgeries:** (Circle all that apply to you)

- |                     |                          |                |              |
|---------------------|--------------------------|----------------|--------------|
| Appendectomy        | Cardiovascular procedure | Cervical spine | Hysterectomy |
| Joint Replacement   | Prostate                 | Lumbar spine   | Gall Bladder |
| Brain               | Shoulder                 | Thoracic spine | Knee         |
| Carpal Tunnel       | Gastro-intestinal        | Uro-genital    | Hernia       |
| Breast Augmentation | Other _____              |                |              |

**Allergies:** (Circle all that apply to you)

- |                |          |                 |             |
|----------------|----------|-----------------|-------------|
| Mold           | Seasonal | Milk or Lactose | Animal      |
| Chemical _____ | Sulfites | Wheat/Glutens   | Other _____ |

**Social History:** (Circle all that apply to you)

- |                |                |                 |          |
|----------------|----------------|-----------------|----------|
| Caffeine use:  | occasional     | often           | never    |
| Drink Alcohol: | occasional     | often           | never    |
| Exercise:      | occasional     | often           | never    |
| Drink Water:   | <64 oz/day     | >64 oz/day      | never    |
| Cigarettes:    | <1 pack/day    | >1 pack/day     | never    |
| Sleep:         | <8 hours/night | >=8 hours/night | Insomnia |
| Other _____    |                |                 |          |

**Family History:** (Circle all that apply)

- |               |               |                |
|---------------|---------------|----------------|
| Arthritis:    | Mother/Father | Brother/Sister |
| Cancer:       | Mother/Father | Brother/Sister |
| Diabetes:     | Mother/Father | Brother/Sister |
| Heart Disease | Mother/Father | Brother/Sister |
| Hypertension  | Mother/Father | Brother/Sister |
| Stroke        | Mother/Father | Brother/Sister |
| Thyroid       | Mother/Father | Brother/Sister |
| Other _____   |               |                |

Father: Deceased? No \_\_\_ Health Problems \_\_\_\_\_ Yes \_\_\_ Cause of Death \_\_\_\_\_  
 Mother: Deceased? No \_\_\_ Health Problems \_\_\_\_\_ Yes \_\_\_ Cause of Death \_\_\_\_\_  
 Significant Health Problems \_\_\_\_\_

**Occupational Activities:** (Circle one that best describes your job description)

- |                          |                     |                    |               |
|--------------------------|---------------------|--------------------|---------------|
| Administration           | Business Owner      | Clerical/Secretary | Computer User |
| Heavy Equipment operator | Daycare/Childcare   | Construction       | Health Care   |
| Food Service Industry    | Medium Manual Labor | Manufacturing      | Home Services |
| Heavy Manual Labor       | Light Manual Labor  | Executive/Legal    | Housekeeper   |
| Other _____              |                     |                    |               |

Doctor's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Review of Systems** – (Check box if you have had trouble with any of the following)

<b>Cardiovascular</b>	Past	Present	No	<b>Respiratory</b>	Past	Present	No	<b>Allergic/Immunologic</b>	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								<b>Ear, Nose and Throat</b>			No
Jaw Pain				<b>Eyes</b>			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
<b>Genitourinary</b>			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				<b>Psychiatric</b>			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				<b>Gastrointestinal</b>			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				<b>Endocrine</b>			No	Bowel Problems			
<b>Neurologic</b>			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				<b>Hematologic</b>			No				
Pinched Nerves					Past	Present		<b>Musculoskeletal</b>			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
<b>Constitutional</b>			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken \_\_\_\_\_

How are your symptoms changing?  Getting better  Not changing  Getting worse

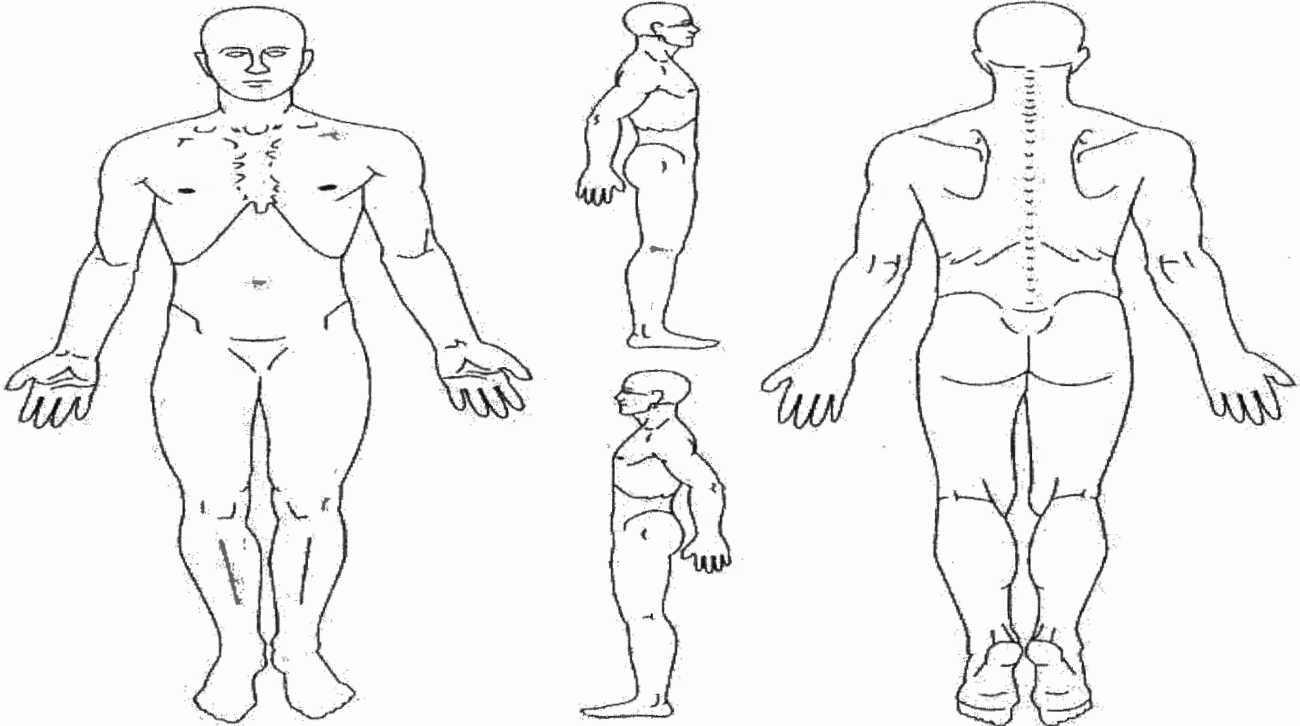
Are You Pregnant? (Check)  Yes  No

Doctor's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness      B=Burning      S=Sharp      T=Tingling      A=Dull Ache



**Average Pain Intensity:**

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

Does anything improve your pain? Yes No If Yes, please list:

When did your symptoms begin? \_\_\_\_\_

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

**How often do you experience your symptoms?**

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  
Burning

Ache  
Tingling

Numb  
Throbbing

Shooting  
Other \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**PRIMARY INSURANCE**

RESPONSIBLE PARTY NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
ADDRESS (if different from patient): \_\_\_\_\_ PHONE: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
RESPONSIBLE PARTY EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_  
GROUP/POLICY #: \_\_\_\_\_ SUBSCRIBER #: \_\_\_\_\_ OTHER: \_\_\_\_\_  
NAME(s) OF OTHER DEPENDENT (s) COVERED UNDER THIS PLAN: \_\_\_\_\_

**ADDITIONAL INSURANCE**

IS PATIENT COVERED BY ADDITIONAL INSURANCE?: \_\_\_\_\_ YES \_\_\_\_\_ NO  
INSURED NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
ADDRESS (if different from patient): \_\_\_\_\_ PHONE: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
RESPONSIBLE PARTY EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_  
INSURANCE ADDRESS: \_\_\_\_\_  
GROUP/POLICY #: \_\_\_\_\_ SUBSCRIBER #: \_\_\_\_\_ OTHER: \_\_\_\_\_  
NAME(s) OF OTHER DEPENDENT (s) COVERED UNDER THIS PLAN: \_\_\_\_\_

**ASSIGNMENT & RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to this clinic 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.

\_\_\_\_\_  
Patient (or responsible party) Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**PAYMENT POLICY**

Thank you for choosing **Hubertus Chiropractic Center** 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 are a non-participating provider in Medicare and we are not in any insurance company’s network. If you are not insured by a plan, payment in full is expected at each visit. If you are insured by a plan, 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 out 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.

**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**