Brighton Chiropractic and Nutritional Health
Chiropractic 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

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 (_____)** _____-_____

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	□ Parent	□ Sibling
Cancer	□ Parent	□ Sibling
Diabetes	□ Parent	□ Sibling
Heart Disease	□ Parent	□ Sibling
Hypertension	□ Parent	□ Sibling
Stroke	□ Parent	□ Sibling
Thyroid	□ Parent	□ Sibling

Other _____

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 _____

Patient Name_____Date_____

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

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
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								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			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				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joint Replacement			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken _____

_____

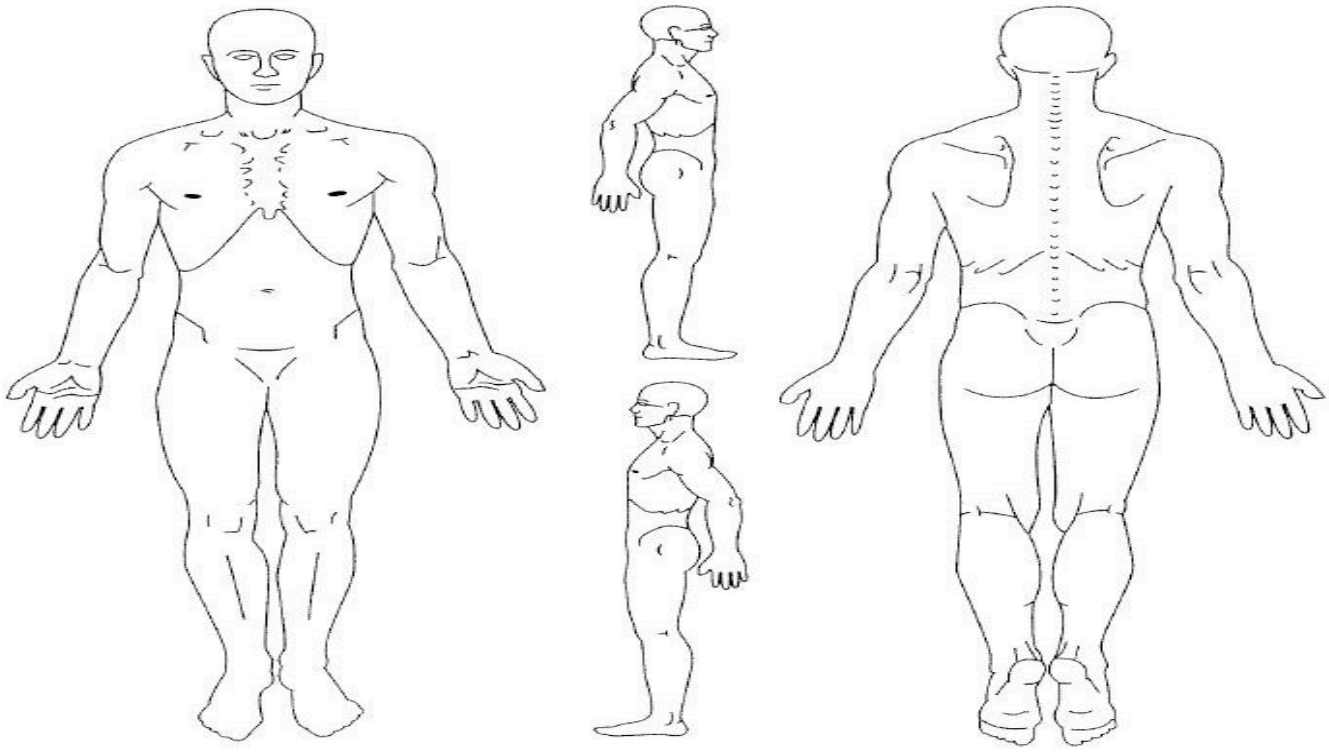
How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Are You Pregnant? (Check) ☐**Yes** ☐**No**

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 □ Ache □ Numb □ Shooting
□ Burning □ Tingling □ Throbbing □ Other _____

Doctor's Signature _____

Patient Name_____Date_____

PAYMENT POLICY

Thank you for choosing Dr. Jamie Brenon and Dr. Elyse House as your Chiropractic providers. 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. Please note if your insurance determines your visit to be not medically necessary our office may charge for that visit.
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 is 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. CONVERAGE 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**. If you are ill, cancelled appointments will not be charged if cancelled 24 hours prior to your 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 understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

Authorizations and Releases

XConsent for Treatment

I, the undersigned, hereby authorize Dr. Brenon or Dr. House and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.
Patient's Signature X_____ Date___/___/___

XAuthorization to Release Medical Information

I authorize Dr. Brenon or Dr. House to release any medical information pertinent to my treatment plan to _____ or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.
Patient's Signature X_____ Date___/___/___

XRequest for Payment of Benefits to Provider of Care

I hereby authorize the _____Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Brighton Chiropractic, 1088 Brighton Road, Tonawanda, NY, 14051. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.
Patient's Signature X_____ Date___/___/___

XAttorney Representation and Protection of Balance

I, the undersigned patient am directing my attorney,_____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.
Patient's Signature X_____ Date___/___/___

XConsent for Treatment of Minor

I hereby authorize Dr. Brenon or Dr. House and whomever she designates as her assistants, to administer treatment as she deems necessary to my child.
Relationship to child:_____
Name of child:_____
Guardian's Signature X_____ Date__/__/__

X-Ray/Medical Records Release

I have requested the release of records of (patients name)_____which are a part of the records at (facility)_____I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.
Please forward this to: Name:_____
Patient's Signature X_____ Date___/___/___

BRIGHTON CHIROPRACTIC AND NUTRITIONAL HEALTH

DR. JAMIE L. BRENON, DC, PLLC
JAMIE BRENON, DC AND ELYSE HOUSE, DC
ERIN RUSSO, LMT AND MELISSA SNEIZAK-SOUTHARD, LMT
1088 BRIGHTON ROAD
TONAWANDA, NY 14150
716-837-1711

HIPAA INFORMATION AND PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provided safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. This means that there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

1) My information will be kept confidential except as is necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary for your care. Possibly at some point, indirect treatment relationships with X-ray facilities or laboratory facilities are necessary. My medical health information provided may have to be disclosed for purposes of treatment, diagnosis, payment or health care operations.

Patient files are stored in closed file cabinets and in our professional electronic medical records system. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than the doctors and office staff.

2) If there are any special concerns that require my personal medical information or my name to be handled in any other measure, I will take responsibility to communicate that to my health care provider.

3) This office may occasionally phone patients and remind them of their appointments. I give permission for office staff to leave messages on my voice mail.

4) The office staff or provider in the reception area may call me by my first name.

5) We agree to provide patients with access to their records in accordance with state and federal laws.

6) I understand that I have the right to refuse consent or disclosure in writing. Under this current law, I understand that the healthcare provider also has the right to refuse care should I refuse to disclose my personal health information. If I am dissatisfied in any way with the way my personal health information is handled at Brighton Chiropractic and Nutritional Health, I have ability to contact HIPPA officer, Dr. Jamie L. Brenon to have the issue resolved.

Print Patient Name:_____
Patient Signature:_____