SCOTT DAVIS CHIROPRACTIC

4012 Katella Avenue, Suite 101
Los Alamitos, CA 90720
P: 562.493.4473
F: 562.667.3893
Scott@ScottDavisChiro.com

New Patient Intake Form

Today's Date: ____ / ____ / _______

Patient Information

Name: ______________________________ Mailing Address: ______________________________

Preferred Name: ______________________________ ______________________________

☐ Male ☐ Female ☐ Decline to Answer

Date of Birth: ____ / ____ / _______

Phone Number: ______________________________ Contact Email: ______________________________

Employer Information

Company Name: ______________________________ Occupation: ______________________________

Health & Social History

Check the box to left if any conditions listed below that apply to yourself:

☐ Alcohol Abuse
☐ Arthritis
☐ Autoimmune Disease
☐ Blood Disease
☐ Bleeding Disorder
☐ Cancer
☐ COPD
☐ Diabetes (DM2 or DM1)
☐ Drug Use
☐ Epilepsy
☐ Emphysema
☐ Gastrointestinal Issues
☐ Genetic Disease
☐ Heart Attack
☐ Hypertension
☐ Psychiatric Condition
☐ Seizure
☐ Stroke
☐ Tuberculosis

Have you been diagnosed with a condition not listed above? Yes ☐ No ☐ If yes, please describe: ______________________
____

Are you currently taking any medication (include regularly used over the counter medications)? Yes ☐ No ☐ If yes, please describe: ____

Do you exercise? Yes ☐ No ☐ If yes, briefly describe the type of exercise and frequency performed:____________________
____

Have you had any surgery or hospitalization? If so, explain: ______________________________________
____

Family History

Check box to left of any conditions listed below that apply to any members of your immediate family:

☐ Autoimmune Disease
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Gastrointestinal Condition
☐ Heart Disease
☐ Stroke
☐ Systemic Arthritide (Gout, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis)

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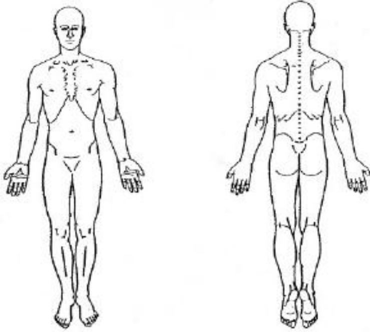
Reason for Today's Visit

ANSWER THE FOLLOWING QUESTIONS IN REGARD TO YOUR PRIMARY COMPLAINT (REASON FOR TODAY'S VISIT)

1. Check box to the left of all that apply: ☐ New Injury ☐ Chronic Injury/Pain ☐ Preventative/Maintenance
2. **Circle** the areas of complaint on the diagram(s) below:



3. Are you currently in pain? Yes ☐ No ☐ If yes, please rate your pain on a scale of 1-10 (10 being the most intense): ____
4. Mechanism of Injury: ☐ Work ☐ Auto-Accident ☐ Athletics ☐ Daily Activities ☐ Unknown ☐ Other: ___________

Brief description of the mechanism of injury: ____

____

Date of injury or start of pain: ____ / ____ / _______ Where were you when the injury occurred? ___________________________

5. Has this injury/complaint occurred in the past? Yes ☐ No ☐

If yes, please describe: ____

6. Have you been treated for the current complaint at an alternative location? Yes ☐ No ☐

If yes, who was the treating physician or party? ____

7. Is your condition interfering with any of the following? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other:

____

8. Which quality of pain/discomfort accurately describes your complaint?

☐ Ache ☐ Burn ☐ Cramp ☐ Dull ☐ Numb ☐ Sharp ☐ Stiff ☐ Tender ☐ Other: ___________________________

9. My pain is currently:

☐ Getting Better ☐ Not Changing ☐ Getting Worse ☐ Other:

____

10. Does your pain radiate to your extremities? Yes ☐ No ☐ If yes, please describe:_______________________________
11. When is your pain at its worst? ☐ Morning ☐ Afternoon ☐ Night ☐ After Activity
12. Alleviating Factors? ☐ Ice ☐ Rest ☐ Lying Down ☐ Sitting Specific Position: _______________________________

☐Other:_________________________

Payment and Insurance Acknowledgement

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with office personnel. If account is not paid within 90 business days, the patient will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting past due fees.

I also authorize the provider and/or office staff to release any information required to process patient's insurance claims.

I understand the aforementioned information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____ ______________________

(Patient/Guardian Signature) (Date)

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Acknowledgement of Services not Covered by Insurance

I hereby acknowledge that a certain portion of my care may not be covered by my healthcare insurance plan under the terms of my benefits plan. I understand and agree to be responsible to self-pay for the following services if not covered by my insurance:

Procedure	Charge
97140 – Manual Therapy (Myofascial Release)	$25
97110 – Therapeutic Exercise	$25
98943 – Chiropractic Manipulation of Extremity	$25

I acknowledge that I have been told in advance of treatment not covered by my insurance that I am responsible for, and I agree to pay for these services.

______________________________ ______________

(Patient/Guardian Signature) (Date)

Patient's Affirmation of Receipt of Patient's Statement of Privacy Rights

I specifically authorize the chiropractic offices of Scott Davis, D.C. to call, text or email for the purpose of reminding me of an appointment that I have scheduled. Additionally, I authorize that office to leave the appointment reminder as a message on my answering machine.

I hereby acknowledge the receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

______________________________ ______________

(Patient/Guardian Signature) (Date)

Payment Policy

I hereby understand:

1. All insurance copays are due at the time of the office visit unless other specific prior arrangements have been made with office staff. I am responsible for a minimum charge of $55 per office visit if our bill is not covered by your insurance or is applied to your deductible.
2. I am responsible for any non-payment by my insurance. The offices of Scott Davis Chiropractic will do their best to help reimbursement from insurance companies by indicating and proving medical necessity for care.
3. I understand that verifying my benefits is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion (co-pay or co-insurance) at the time of service. I agree to pay/settle any denied and/or unpaid claims. I understand payment is due in full, upon notification from this office. I personally may have to pursue reimbursement directly from the insurance company or third party payer.

I understand and accept the aforementioned payment policy terms.

______________________________ ______________

(Patient/Guardian Signature) (Date)

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No Show Fee

I acknowledge that I must notify the office of Scott Davis Chiropractic at least 24 hours prior to my appointment of any changes or reschedules to that appointment. Failure to do so will result in a $30 “no-show” fee. I understand and accept the aforementioned payment policy terms.

____ ________________

(Patient/Guardian Signature) (Date)

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other indicated chiropractic procedures, including various modes of physiotherapy and manual therapy (e.g. myofascial release) on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Scott Davis, D.C.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect to any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by Scott Davis Chiropractic.

Affirmed,

____ ________________

(Patient/Guardian Signature) (Date)