WRIGHT FAMILY CHIROPRACTIC, PLLC
2301 CAMDEN AVENUE, PARKERSBURG, WEST VIRGINIA 26101
(304) 422-2301
FAX: (304) 422-2302

Please Print all Answers

NEW PATIENT INFORMATION

Name _____ Age _____ Sex _____ Date _____

Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Best time to Call _____ Which # _____ E-mail _____

Social Security # _____ Birthdate _____ Family Doctor _____

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name _____

Employer _____ Spouse's Employer _____

Employer Address _____ Spouse's Birthdate _____

Employer Phone _____ Spouse's Social Security _____

Parent's Employer If Patient Is Minor / Child _____

Parents Social Security # If Patient Is Child _____

Emergency: Who Do We Call? _____ Relationship _____

Name of Relative or Friend Not Living with You Phone

REFERRAL INFORMATION

WHO recommended you to our office? ☐ My Doctor ☐ Family / Friend ☐ _____

Name _____ Address or Phone _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birthdate _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____

Agent Name _____ Adjuster's Name _____

Accident Claim Number _____ Phone Number _____

Name of LIABLE Insurance Company _____ Adjuster's Name _____

Claim Number _____ Phone Number _____

Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____

Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

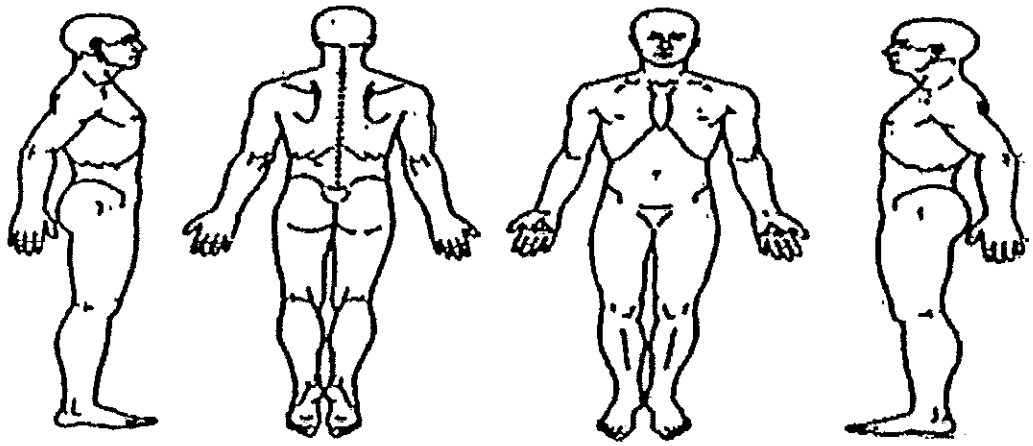
Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. If you do not show up for your scheduled appointment you will be charged $15.00 as a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
   - ◻ Constantly (76-100% of the time)
   - ◻ Frequently (51-75% of the time)
   - ◻ Occasionally (26-50% of the time)
   - ◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - ◻ Sharp
   - ◻ Dull
   - ◻ Diffuse
   - ◻ Achy
   - ◻ Burning
   - ◻ Shooting
   - ◻ Stiff
   - ◻ Numb
   - ◻ Tingly
   - ◻ Sharp with motion
   - ◻ Shooting with motion
   - ◻ Stabbing with motion
   - ◻ Electric like with motion
   - ◻ Other:_____

5. How are your symptoms changing with time?
   ◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
   ◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

8. How much has the problem interfered with your social activities?
   ◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

9. Who else have you seen for your problem?
   - ◻ Chiropractor
   - ◻ ER physician
   - ◻ Massage Therapist
   - ◻ Neurologist
   - ◻ Orthopedist
   - ◻ Physical Therapist
   - ◻ Primary Care Physician
   - ◻ Other:_____
   - ◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
    ◻ Yes ◻ Yes, at times ◻ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		For Females Only	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ Date:_____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____

Patient's Signature Date

X-RAY QUESTIONNAIRE: **FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ Yes. I am definitely pregnant
- ☐ No. I am definitely not pregnant at this time
- ☐ I request that x-ray films not be taken because _____

_____

_____

Date of last menstrual period: _____

_____

Patient's Signature Date

HIPPA

ACKNOWLEDGMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and healthcare operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

DATE:_____

PATIENT NAME:_____

(SIGNATURE):_____

WITNESS:_____

Wright Family Chiropractic
2301 Camden Avenue
Parkersburg,WV 26101

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IRREVOCABLE ASSIGNMENT,LEIN AND AUTHORIZATION INSURANCE BENEFITS

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you,my insurance carrier,to pay directly to Wright Fmaily Chiropractic,PLLC such sums as may be due and owing this office for services rendered to me,both by reason of accident or illness and by reason of any other bills that are due to this office and withhold such sums from any disability benefits,medical payment benefits,or any other insurance benefits obligated to reimburse me from any settlement,judgment or verdict on my behalf as may be necessary to adequately protect Wright Family Chiropractic PLLC. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement,judgment or verdict which may be paid to me as a result of my injuries or illness for which I have been treated for by Wright Family Chiropractic PLLC. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due to the office for services rendered. I further understand and agree that this Assignment,Lien, and Authorization does not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this Assignment,Lien and Authorization and authorize and direct Wright Family Chiropractic PLLC to appeal denails or payments at all levels on my behalf.
I agree never to rescind this document and that a rescission will not be honored by my insurance company. I hereby instruct that in the event another insurance company is substituted in this matter,the new insurance company will honor this agreement as inherent to the settlement and enforceable on the case as if it were executed by the company.

Patient Signature: _____ **Date:** _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare,your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

1. *Cancellation/ No Show Policy for Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However,when you do not call to cancel an appointment,you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $15.00 fee; this fee will not be covered by your insurance company. This amount must be paid in full prior to your next appointment.

****Please note: Not receiving a reminder call from our office is NOT an acceptable excuse for missing an appointment. These reminder calls should be considered a "bonus" to keep you on track with your schedule and should not be relied upon as your sole method of knowing when your appointment is.**

2. *Scheduled Appointments*

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment! Please arrive no earlier than 15 mins.before your scheduled appointment time! Showing up any earlier will not get you back ahead of the other patients who are scheduled at that time!

3. *Massage Appointments*

If you arrive late, your massage session may be shortened in order to accommodate others whose appointments follows yours. Depending upon how late you arrive,the massage therapist will then determine if there is enough time remaining to start your massage. Out of respect to the massage therapist and other patients,please plan accordingly and be on time.

4. *Insurance Information*

It is your responsibility to provide us with a current/correct insurance card! If you do not provide us with the correct information and we receive a denial from the insurance company you will be billed for the entire visit that you did not give us correct insurance information.

_____	_____	___/___/___
Print Patient Name	Signature Patient/Guardian	Date