Sam Harwood D.C.
(785) 764-2087
www.harwoodchiro.com

HARWOOD CHIROPRACTIC

3320 Clinton Parkway Ct
STE 110
Lawrence, KS 66047

New Patient Intake Paper Work

Name: _____ **Age**: _____ **Today's Date**: ____/____/_____

Date of Birth: ____/____/_____ **Sex**: ☐ Male ☐ Female

Home Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Contact Phone: _____ Cell / Home / Work

Email: _____

Occupation: _____ Employer: _____ Employer Phone:_____

Marital Status: Single / Married / Divorced / Widowed / Other

Social Security Number: _____-_____-_____ Race: _____

Emergency Contact

Name: _____ **Phone**: _____ **Relationship**: _____

Primary Care Physician: _____ Office Name: _____

May we contact your primary care physician to inform them you are receiving chiropractic care?

YES / NO

Payment Information

Circle One: Blue Cross & Blue Shield Medicare Cash/ Chiro Health USA

Workman's Compensation Auto Insurance United Health Care

Ins. Company: _____ Policy Number: _____ Group #:_____

Name of Insured: _____ Relationship to Patient: _____

Insured's Employer: _____ Employer's Phone: _____

Secondary Insurance: Yes / No

Company Name: _____ Policy Number: _____

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What brings you in today? What issues do you have? _____

_____

_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		**3)** _____	
2) _____		**4)** _____	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No

If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c>9.0%?

❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

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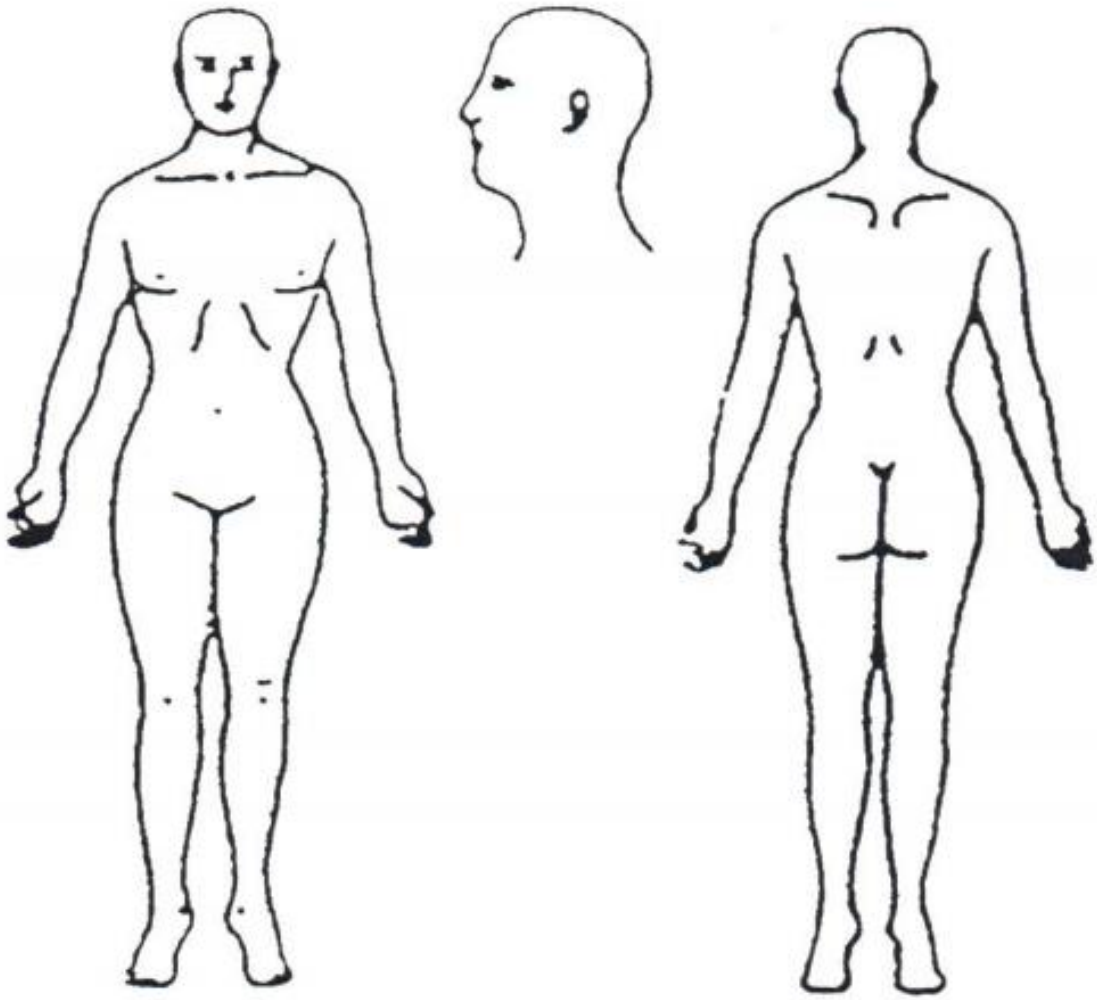
Symptom Diagram

Please be sure to fill this form out as accurately as possible. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ^^^^ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



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Blanket Authorizations and Authorizations to Release Information: I understand that the following authorizations are to be used by Harwood Chiropractic LLC to affect the collection on the date of the first service rendered. Copies of this agreement will be as valid as the original. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. I also hereby authorize Harwood Chiropractic LLC to release information concerning my state of health, history, treatment, and progress to any party associated with this case.

Authorization to Pay Insurance Benefits: I hereby authorize directly to Harwood Chiropractic LLC the benefits payable under all plans of health insurance otherwise payable to me but not to exceed the provider's charges for the period of treatment. I further understand that I am financial responsible for payment of charges not covered by this authorization.

Legal / Collection Fee: I agree to pay all reasonable fees of attorneys and/or collection agencies needed to affect collection of any delinquent charges outstanding on my account. I also agree that, if at any time there is a need for legal action to be brought against any insurance company or other guarantors, I will be responsible for investigating such action.

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I UNDERSTAND THE ABOVE POLICY AND ITS CONTENTS

Patient Name (Please Print): _____

Patient Signature: _____ **Date: _____/_____/_____**

End of Document