PATIENT INTAKE FORM

Patient Information:

Name_____ Date of Birth ____/____/_____

Social Security Number _____ - _____ - _____ Age _____ Sex _____

Permanent Address _____ Apt. No. _____

City _____ State _____ Zip _____

Local Address (if same as permanent address write "same as above") _____

City _____ State _____ Zip _____

Telephone Number: Home (___) _____ - _____ Cell (___) _____ - _____

Work (___) _____ - _____ Other (___) _____ - _____

Name of employer_____ Occupation _____

☐ Married-Spouses Name _____ ☐ Divorced ☐ Widow ☐ Single

We will need a copy of your Drivers License/I.D. Card

Medicare Information:

Is Medicare your primary insurance? ☐YES ☐NO

Insured's Name_____

Medicare Number _____

Medicare Lifetime Signature Form

I authorize the release of any medical information necessary to process any claim(s) to this physician. I also request payment of government benefits whether to myself, if assignment has not been taken, or the physician if he chooses to accept assignment on my claim(s). If assignment is accepted on my particular claim(s), I agree to pay any deductible or co-insurance for that particular claim(s).

Signature _____ Date _____/ _____/ _____

We will need a copy of your Medicare card

Private Insurance:

Insurance Company_____PPO/HMO/POS

Policy # _____ Group # _____

Insured's Name_____ Relation_____

Insured's Soc.Security# _____ - _____ - _____ Insured's Date of Birth ____/____/_____

By signing below I understand and agree, it is my sole responsibility as patient to notify the physician's office of any and all changes in my health insurance plan/policy. I understand failure to do so in a timely manner may result in the charges being my sole responsibility. I also authorize release of any and all personal health information necessary to process any claim(s) to this office. I have read and understand all the above.

Signature_____ Date ____/____/_____

We will need a copy of your insurance card(s)

Form of Payment:

I understand that payment for each date of service is due in full at the time services are rendered, unless other arrangements have been made in advance.

I understand that full payment is due of all co-pays and /or outstanding balances at time of check-in, prior to and as condition of services being rendered, unless other arrangements have been made in advance.

I understand that failure to comply with the above may result in immediate termination of the patient-physician relationship and all outstanding balances will become due immediately.

Records remain the property of this clinic.

Form of payment

☐Cash ☐Check ☐Credit Card ☐Other_____

Signature_____ Date ____/____/_____

GIANETTI CHIROPRACTIC CENTER, P.A.

27400 RIVERVIEW CENTER BLVD. STE. 1

BONITA SPRINGS, FLORIDA 34134

239-301-2319/ FAX: 239-301-0435

Chief Complaint (s):

_____

_____

_____

Related to a fall or accident? _____

Location of complaint:_____

Complaint began when and how_____

Please circle the quality of pain/complaint: dull, sharp, shooting, throbbing, deep, nagging, other_____

Does the complaint/ pain radiate or travel to any areas of your body?
Where?_____

Do you have any numbness or tingling in your body? Yes/ no ?
Where?_____

Grade intensity / severity of pain/ complaint: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

How frequent is the complaint present? How long does it last?

_____

Does anything aggravate the complaint/ pain?

_____

Does anything make the complaint/ pain better?

_____

Previous treatment, medications, surgery, or care you sought for your complaint/ pain?

_____

_____

What do you want to achieve with Chiropractic care? _____**Relief of symptoms** _____ **Total Corrective Care**

Past History:

Have you ever been diagnosed as having or suffering from:

_____ Muscle Disorder	_____ Lungs, asthma	_____ arthritis
_____ Nervous System Disorder	_____ Broken Bones	_____ Epilepsy
_____ Bone Disorder	_____ Eating Disorder	_____ Cancer
_____ Alcoholism	_____ Pace Maker	_____ RA
_____ Drug Addiction	_____ Allergies	_____ Strokes
_____ Seizures/Convulsions	_____ Gallbladder	_____ HIV
_____ Congenital Disease	_____ Excessive Bleeding	_____ Ulcer
_____ Ears/eyes/nose/throat	_____ Depression	_____ Hernias
_____ High Blood Pressure	_____ Coughing Blood	_____ Tumors
_____ Low Blood Pressure	_____ Kidney/Bladder	_____ Diabetes
_____ Circulatory Problems	_____ Stomach/Intestines	_____ Heart
_____ Pacemaker		

Explain treatment for condition checked off above:

_____

_____

_____

_____

Are you pregnant?:_____

How many children do you have? _____

List any surgeries you have had:

_____

Childhood Illnesses:

_____

Do you use alcohol, tobacco, or drugs?

_____

List any medication you currently take:

_____

_____

Previous chiropractic care:

_____

_____

_____