NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name:_____ Today's Date:_____

Address:_____

City/State/Zip:_____ E-Mail:_____

Phone: Home _____ Work:_____

Cell #:_____ Marital status: M/W/D/S

How would you prefer to receive appointment reminders?

☐ Phone call ☐ Email ☐ Text Carrier:_____

Birthdate:_____/_____/_____ Age:_____ Social Security #:_____

Occupation:_____

Employer name: _____ Phone: _____

Employer's address:_____

Spouse's name:_____
Spouse's employer:_____

Who may we thank for referring you? _____

Your prior Doctor of Chiropractic:_____

City, State: _____

Chiropractic adjusting techniques you've had success with:_____

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner name:_____ Phone: _____
Address, City, State: _____

Please rate on a scale of 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP: _____

Other Specialists you are currently under care with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Children's names & ages:_____

_____

Favorite hobbies or interests:_____

_____

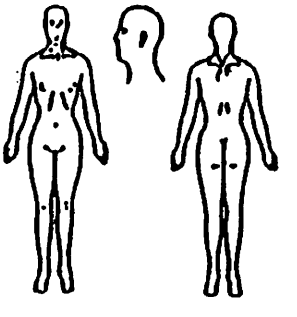
Health reasons for consulting our office:
1._____ 2._____

3._____ 4._____

Have you had same or similar problem(s) before?___Yes ___No
How long?: _____ Please explain:

_____

Mark area(s) of
Health Concerns



Father/Mother/Brother/Sister/Children, with similar problems?

Is this the result of an auto or work injury?_____If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

Other doctors who have treated this problem:_____

Surgery you have had (ALL):_____

Medication(s) you currently take:_____

Is there any chance you are pregnant? Yes____ No_____

What do you understand chiropractic care to be?

Do you know what a subluxation is? Yes or No If yes, please describe:

What daily rituals for spinal health do you presently practice?

Have you ever been diagnosed with cancer?___ If so, what type?

Do you have health insurance?_____ Name of company:_____

Name of Policy Holder _____ Relationship (self,spouse,parent) _____

Insured DOB_____ Insured SS#_____

Method of payment for first visit:

_____Cash _____Check _____MAC _____Credit Card

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:_____ Date:_____/_____/_____

Authorization of Release:

We at McCormick Chiropractic firmly believe that open communication between all of your Doctors is vital to optimal care being rendered. Therefore, we respectfully request your permission to forward relevant information to the above stated Doctors.

Permission to forward relevant information regarding my care to the above stated doctors.

Patient's signature: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

McCormick Chiropractic
553 West Ridge Pike
Limerick PA 19468

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____