MACOMB SPINE CARE
1-800-Rx-MySpine
THE LEADER IN NON-SURGICAL SPINE & DISC CARE

New Patient Intake

Date:_____

Name:_____ SS#:_____-____-_____ Date of Birth:_____ Age:____ ☐Male ☐Female

Address:_____ City:_____ State:_____ Zip:_____

☐Single ☐Married ☐Divorced Email: _____Cell /Phone: _____

Emergency Contact:_____ Phone:_____ Relationship:_____

How did you hear about our office?
☐Online ☐Drive By ☐Walk-In ☐Yellow Pages ☐Referral (Please tell us who)_____ ☐Other:_____

Health Insurance Information
Primary Insurance:_____Policy Holder's Name:_____ DOB:_____
Policy Holder's Relationship to Patient: _____

Accident Information (SKIP this section if you were not involved in an accident)
Is your condition due to an: ☐Auto Accident ☐Work Injury ☐Slip and Fall ☐Other Accident (Describe below)
Date of Accident:_____ Adjustor's Name:_____ Adjustor's Phone:_____
Auto/ Work Insurance:_____
If Auto Injury, have you reported the accident to your insurance company? ☐No ☐Yes Claim#_____
If Work Injury, have you reported the accident to your supervisor/ boss? ☐No ☐Yes Claim#_____
If Slip and fall or Other Type of Injury, please describe:_____
Do you have an Attorney for you Auto or Work Comp. injury? ☐No ☐Yes
Please provide Attorney Name, address, and phone#:_____
_____

Current Complaint
Please list your worst complain:_____
How long have you had it:_____
How did it start:_____
A) Is it: Improving Worsening Same **B)** Is it: Mild Moderate Severe
C) What worsens it: ☐General Activity ☐Moving wrong ☐Bending ☐Lifting ☐Walking ☐Sports
D) What makes it better: ☐Rest ☐ Ice Packs ☐Heating Pad ☐ Medication ☐Other_____
E) Is it worse in the: ☐AM ☐ PM ☐After day wears on ☐ Constant Off and on
F) Is the symptom: ☐ Dull and Achy ☐ Tight and Stiff ☐ Sharp and Stabbing ☐ Numb and Tingling ☐ Shooting

II. Please list you 2nd worst complaint:_____ How long have you had it:_____
How did it start:_____ **A)** Is it: ☐Improving ☐Worsening ☐Same **B)** Is it: ☐Mild ☐Moderate ☐Severe
C) What worsens it: ☐General Activity ☐Moving wrong ☐Bending ☐Lifting ☐Walking ☐Sports
D) What makes it better: ☐Rest ☐General Activity ☐Ice Packs ☐Heating Pad ☐Medication ☐Other _____
E) Is it worse in the: ☐AM ☐ PM ☐After day wears on ☐ Steady ☐ Off and on
F) Is the symptom: ☐Dull and Achy ☐Tight and Stiff ☐Sharp and Stabbing ☐Numb and Tingling ☐Shooting

NAME, ADDRESS, PHONE # OF PRIMARY CARE DOCTOR:_____
_____

PLEASE CHECK IF YOU WOULD LIKE :

☐I authorize Macomb Spine Care to send text reminders and/or Emails regarding appointments.

☐I authorize Macomb Spine Care to send marketing and/or promotional emails regarding special offers.

Patient Name:_____ Date:_____

MEDICARE PATIENTS (Check One): Would you like to be able to:
☐Bend and lift with no pain ☐Get up from sitting with no pain ☐Get a good night's sleep with no pain
☐ Read with no pain ☐ Work at a computer with no pain ☐ Do your housework with no pain
☐Do your yard work with no pain ☐Play sporting activities with no pain

Current Health

- Name and phone number of family doctor:_____
- List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc):_____ Date of last eye exam:_____
- If you are currently taking any prescription or nonprescription medications, please list them below:

Medication:_____ Dose:_____ Medication_____ Dose:_____
Medication:_____ Dose:_____ Medication_____ Dose:_____

- Please list any medications you are allergic to:_____
- Please indicate your height and weight:____' _____"____lbs What is your usual blood pressure:____/____

Health History

- List any operations, surgeries or medical procedures:
  Date:_____ Procedure:_____ Date:_____ Procedure:_____
  Date:_____ Procedure:_____ Date:_____ Procedure:_____
- If you have ever had in the past or currently have any serious illnesses or injuries, please list:
  Date:_____ Condition:_____ Date:_____ Condition:_____
  Date:_____ Condition:_____ Date:_____ Condition:_____

Any current loss of bowel or bladder control: ☐No ☐Yes Any unexplained weight loss: ☐No ☐Yes
Any current seizures, paralysis, speech, vision problems:☐No☐Yes Current nutritional problems:☐No ☐Yes

- Please list any significant family illnesses:_____
- Have you had spinal X-Rays within the past 5 years? If yes, when and where:_____
- Do you have a pacemaker?☐No ☐Yes If yes, please ALERT our receptionist.
- Do you have any blood/ lymph disorders?☐No ☐Yes If yes, please list:_____
- Do you have osteoporosis or rheumatoid arthritis? ☐No ☐ Yes
- Please list any other electrical device that you currently wear:_____
- Please select one: ☐I have never smoked ☐ Former smoker ☐ Current smoker, ____pk./day _____ pk./wk.
- Please select one: ☐I don't drink ☐Rarely drink ☐Social drinker ☐ Heavy drinker (____oz. per day/wk)
- Have you ever had chiropractic care:☐No ☐Yes If yes, last date of treatment_____ by whom:_____

Similar or different condition:_____ Results:_____
What are your overall expectations from your treatment with our doctor:_____

I the undersigned hereby give my consent for the doctor to examine and treat my condition as he/ she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to take x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case.

- WOMEN ONLY: I hereby declare that to the best of my knowledg☐ I am pregnan☐ I am not pregnant. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

Patient Print:_____

Patient Signature:_____ Date:_____

(Parent/ Guardian signature if under 18 years of age)

General/ Financial Policy

Welcome to Macomb Spine Care. We strive to provide you with excellent Chiropractic care in a clean, friendly, professional setting and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- You account is to be kept current. All self pay or insurance copayments, co-insurances and deductibles will be collected at the time of service payable by cash, check, Visa, Mastercard, Discover, American Express, or Care Credit.
- If you do not have your payment(s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us no late then the day before so that we may offer that time to another patient. There is a $30.00 charge for missing an appointment without proper notification.
- You will only be sent a statement if your balance exceeds $5.00.
- There is a $25.00 charge for the completion of paperwork (ex. Disability, FMLA, etc).
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs, and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. We must emphasize that as medical providers, our relationship is with you, not your insurance company. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry.

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes in your insurance policy so that your coverage can be re-verified
- Not all services are a covered benefit with all insurance plans
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance company.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a MEDICARE PATIENT, please be advised that Medicare only covers Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. WE ARE HERE TO HELP YOU.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Printed Name	Signature of Patient/ Legal Guardian	Date

CONSENT TO RELEASE INFORMATION: In the event that you ever with to have a family member or friend come to our office and get a copy of your medical records for whatever reason, we ask that you sign below allowing them to do so. By signing below I hereby give my consent for Macomb Spine Care to release me medical records to:

_____	_____	_____
Name of Family Member/ Friend	Signature of Patient/ Parent. Legal Guardian	Date

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for the Chiropractic Physician at Macomb Spine Care to examine, and if needed, treat my minor child_____.

Print child's name here

_____	_____	_____
Printed Name	Signature of patient/ Legal Guardian	Date