# Delran Chiropractic, PA
# Chiropractic Physicians & Wellness Center

3001 Bridgeboro Road
Delran, New Jersey 08075
Phone: 856-461-6262
Fax: 856-461-7798
www.polinowellness.com

**Patient Intake Form**
*(please print clearly)*

**Patient Information**
First Name: _____ Middle Name: _____ Last Name: _____
DOB: _____ Sex (circle applicable): Male Female Other: _____
Height: _____ Weight: _____ Social Security #: _____
Married/civil union (circle applicable): Married Single Divorced Widow(er)
Spouse name: _____ # of children: _____
Home #: _____ Cell #: _____ Wireless Carrier: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____

**Employer Information**
Employed (circle applicable): Full time Part time Unemployed
Employer Name: _____ Occupation: _____
Employer Address: _____
Employer City: _____ Employer State: _____ Employer Zip: _____
Work Supervisor Name: _____ Supervisor Phone #: _____
Physical Work Duties: _____

**Reason for Visit**
Describe the reason for this visit: _____
Impact on life: _____
When did this concern begin? _____
Has this concern (circle applicable): Gotten Worse Stayed Constant Come and Gone
Does this concern interfere with (circle applicable): Work Sleep Daily Routine Other Activities
Explain: _____
Has this concern occurred before? Yes No
Explain: _____
Have you seen other doctors for this concern? Yes No
Doctor's Name: _____
Type of Treatment: _____
Results (circle applicable): Good Bad Indifferent

**Chiropractic Experience**

How did you find our office (circle applicable)? Newspaper Sign Community Event Mailing Google Patient

If applicable, who referred you to our office? _____

Have you been adjusted by a Chiropractor before (circle applicable)? Yes No

If yes, what was the reason? _____

Doctor's Name: _____

Date of last visit: _____

Has any member of your family ever seen a Chiropractor? Yes No

**Female Only** *(please circle applicable options)*

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control? Yes No

Do you have irregular cycles? Yes No

Do you experience painful periods? Yes No

Do you have breast implants? Yes No

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## REVIEW OF SYSTEM FORM

Name: _____ Date: _____
Tobacco Use: YES/NO How much per day? _____ How Long? _____ Date Quit_____
Alcohol Use: How much per day? _____
Caffeine (Coffee, Teas, and/or Colas): How much per day? _____

**PAST ILLNESSES**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | Hepatitis | | | Phlebitis | | |
| Anemia | | | High Blood Pressure | | | Rheumatic Arthritis | | |
| Asthma | | | High Cholesterol | | | Stroke | | |
| Cancer | | | HIV | | | Thyroid Disease | | |
| Depression | | | Lung Disease | | | Tuberculosis (TB) | | |
| Diabetes | | | Mental Illness | | | Ulcer in GI Tract | | |
| Drug Abuse | | | Osteoarthritis | | | Venereal Disease | | |
| Epilepsy/Seizures | | | Osteoporosis | | | Other: | | |
| Glaucoma | | | Other Immune Disease | | | Other: | | |
| Heart Disease | | | Phlebitis | | | | | |

**PAST SURGICAL HISTORY:** (PLEASE INCLUDE DATES)
_____
_____
_____
_____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

| **NERVOUS SYSTEM:** | Yes | No |
|---|---|---|
| Epilepsy | | |
| Seizures | | |
| Fainting Spells | | |
| Loss of Consciousness | | |
| ADHD | | |
| ADD | | |
| Cerebral Palsy | | |
| Head Injury | | |
| Headaches | | |
| Migraines | | |
| **PSYCHOSOCIAL:** | | |
| Anxiety | | |
| Depression | | |
| Counseling Service | | |
| Mental Illness | | |
| **HEART:** | | |
| High Blood Pressure | | |
| Chest Pain | | |
| Angina | | |
| Heart Attack | | |
| Pacemaker | | |
| Mitral Valve Prolapse | | |
| Heart Murmur | | |
| Irregular Heartbeat | | |
| Palpitations | | |
| Skipped Beats | | |
| Heart Surgery | | |
| **LIVER:** | | |
| Hepatitis | | |
| Jaundice | | |
| Liver Disease | | |

| **LUNG:** | Yes | No |
|---|---|---|
| Asthma | | |
| Hay Fever/Sinus | | |
| Emphysema/COPD | | |
| Shortness of Breath | | |
| Croup | | |
| Bronchitis | | |
| Recent Cold/Cough | | |
| TB | | |
| Pneumonia | | |
| Chew Tobacco | | |
| **ANESTHESIA:** | | |
| Nausea/Vomiting After | | |
| Family History - Problems | | |
| **GI/GU** | | |
| Hiatal Hernia | | |
| Stomach Ulcer | | |
| Kidney Disease | | |
| Unexplained Recent Weight Loss/Gain | | |
| Gastric Reflux | | |
| Indigestion | | |
| Motion Sickness | | |
| **ENDOCRINE:** | | |
| Diabetes | | |
| Thyroid Disease | | |
| Insulin Dependent | | |
| Hypoglycemia | | |
| **DENTAL:** | | |
| Bridges, Partials, Dentures | | |
| Loose or Missing Teeth | | |
| TMJ | | |

| **MUSCULOSKELETAL:** | Yes | No |
|---|---|---|
| Arthritis | | |
| Painful Stiff Joints | | |
| Prosthesis: _____ | | |
| Back Pain | | |
| Metal Implants: _____ | | |
| _____ | | |
| Physical Limitations: _____ | | |
| _____ | | |
| **BLOOD:** | | |
| Bleeding Disorder | | |
| Previous Blood Transfusions | | |
| Eye Glaucoma | | |
| Eye – Other | | |
| **AIRWAY:** | | |
| Problem Opening Mouth Wide | | |
| Problem Turning Head in Any Direction | | |
| Sleep Apnea | | |
| Snoring | | |
| **ALLERGIES:** | | |
| Latex | | |
| Medications | | |
| Dyes/Tape | | |
| Shellfish | | |
| Foods | | |
| Loss of Strength | | |
| Numbness | | |
| Headaches | | |
| Tremors | | |
| **WOMEN'S HEALTH:** | | |
| Pregnant? | | |

SIGNATURE/REVIEWING PHYSICIAN _____

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# Electronic Health Records Intake Form

*In Compliance with Medicare requirements for the government EHR incentive program*

First Name_____ Last Name_____ Zip Code_____

Email Address_____ Cell#_____ Cell Provider_____

Preferred method of Communication for patient reminders (Circle one): Text message / Phone Call

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 / Decline to Answer

**Ethnicity(Circle One):** Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

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

| Medication Name | Dosage and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |

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:**_____/_____

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Initial Visit = $110.00
Initial Exam = $60.00
Cash Adjustment = $50.00

Patients who pay for a cash adjustment and receive 1 or more modalities during each visit will receive a 50% discount for each modality. This 50% discount results in each modality costing $12.50.

For example:

- Cash adjustment ($50.00) + 1 modality = $62.50
- Cash adjustment ($50.00) + 2 modalities = $75.00
- And so on and so forth.

Nutritional visits and xrays are an additional fee.

Patient Name: _____
Patient Signature: _____
Date: _____
Doctor: _____

DELRAN CHIROPRACTIC PA

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-14-2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other health care provider providing treatment to you. Treatment may be administered in an open room format.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations: include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies; x-rays, or other similar forms of health information.

**Marketing Health-Related services:** We will not use your health information for marketing communications without your written authorization for example. (puzzle boards, thank you board)

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are.

a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as rescheduling rmissed appointments, phone calls, voicemail messages, postcards or letters).

## PATIENT RIGHTS

**Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice; If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting**: You have the right to receive a list of instances in which we of our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14,2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

**Restriction**: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication**: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice**: If you received this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. QUESTIONS AND COMPLAINTS. If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your, privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if, you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr Jason Polino DC
Office Telephone: 856-461 -6262
Billing Telephone: 8564616249 contact person: Jeni Polino
Fax 856-461-7798
Address: 3001 Bridgeboro Road
Delran ,NJ 08075

Patient's Signature & Date:_____