

## Patient Intake Form

### Patient Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
                    First                                    MI                                    Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Female: \_\_\_\_\_ Male: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

### Payment Information

Person Responsible for Payment: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Insurance Information

Do you have health insurance? \_\_\_\_ Yes \_\_\_\_ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

**Please have your insurance card and driver's license ready so they can be copied for the clinic's records.**

### Consent for Treatment

**Assignment & Release** - By signing below, I authorize Dr. Lindsey Green-McCoy D.C. to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Dr Lindsey Green-McCoy D.C. and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed \_\_\_\_\_ Date \_\_\_\_\_

Dr. Lindsey Green-McCoy

## Health Questionnaire

### Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

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List any surgeries or hospitalizations you have had complete with the month and year for each:

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List anything you are allergic to: \_\_\_\_\_

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

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Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_

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Are you dieting?  Yes  No Since: \_\_\_\_\_ Do you smoke?  Yes  No \_\_\_\_\_ packs per day.

How many years have you been smoking? \_\_\_\_\_ Do you drink alcoholic beverages?  Yes  No \_\_\_\_\_ drinks per day.

Do you wear?  Heel lifts  Arch supports  Prescription Orthotics

For women: Are you pregnant or nursing?  Yes  No If pregnant, How many weeks? \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

Dr. Lindsey Green-McCoy

## Medical History

Describe the reason(s) for your doctor visit today:

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Are you here because of an accident? \_\_\_\_\_ What type? \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_ How did your symptoms begin? \_\_\_\_\_

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? \_\_\_\_\_

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Have you experienced these symptoms in the past? \_\_\_\_\_

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## History of Treatment

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date last seen: \_\_\_\_\_ May we update them on your condition? \_\_\_Yes \_\_\_ No

Have you seen a chiropractor before? \_\_\_Yes \_\_\_ No Who referred you to us? \_\_\_\_\_

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: \_\_\_\_\_

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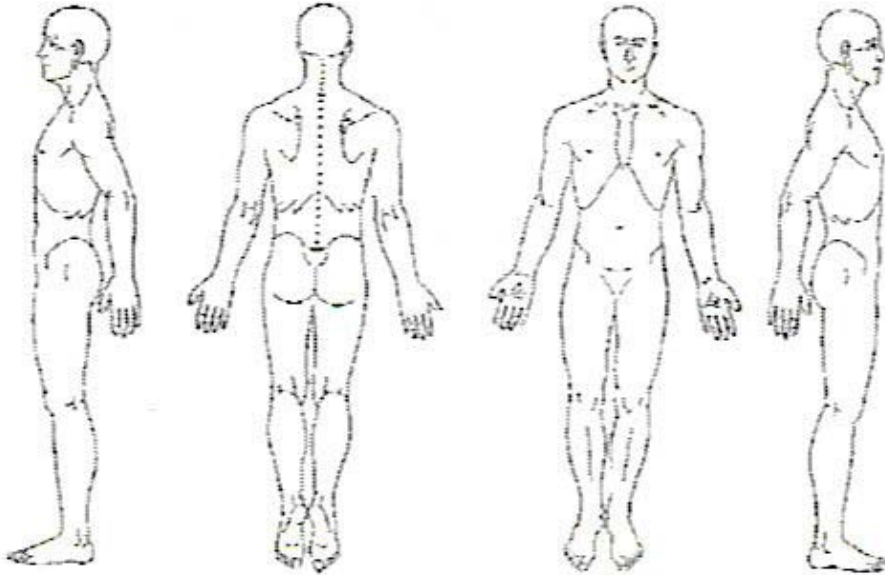
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## Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left

Back

Front

Right

On a scale of one to ten how intense are your symptoms? Not intense ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

Dr. Lindsey Green-McCoy

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder
<input type="radio"/>	<input type="radio"/>	Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control
<input type="radio"/>	<input type="radio"/>	Allergies Headache	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Low back pain
<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Mid back pain
<input type="radio"/>	<input type="radio"/>	Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Neck pain
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Shoulder pain
<input type="radio"/>	<input type="radio"/>	Birth Control Pills	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Smoking/tobacco Use
<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome
<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Upper back pain
<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain	<input type="radio"/>	<input type="radio"/>	Wrist pain

Additional comments you would like the doctor to know: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's signature: \_\_\_\_\_ Doctor's signature: \_\_\_\_\_

## Financial Policy

### Insurance Coverage

Welcome to Dr. Lindsey Green-McCoy D.C. LLC. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of \$100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your \$100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

### Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

#### Private Pay: (please initial)

**A**\_\_\_\_\_ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

**B**\_\_\_\_\_ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

#### Health Insurance: (please initial)

**C**\_\_\_\_\_ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

### Missed Appointments

It is the policy of **Dr. Lindsey Green-McCoy D.C. LLC** to assess a **\$45** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

\_\_\_\_\_ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date