**Complete Wellness & Integrated Health Center** ***Stephanie Cluver, D.C.***
***DBA: Clinton Chiropractic Center***
**211 S. Quincy St. Clinton, IL 61727 Phone (217) 935-6555**

# Patient Intake Form

**Date:** _____

_____

**(Legal) First Name** **(Legal) MI** **(Legal) Last Name** **Birthday**

**Gender**: [ ] Male [ ] Female **Marital Status:** [ ] Single [ ] Married [ ] Other _____

[ ] Employed [ ] Full Time Student [ ] Part Time Student [ ] Other _____

**Social Security # _____ - _____ - _____**

**How did you hear about our office / or from who?:** _____

**Race:** [ ] White [ ] Black or African American [ ] Hispanic or Latino [ ] Asian [ ] American Indian or Alaska Native

[ ] Native Hawiian/Other Pacific Islander [ ] Other _____

**Ethnicity:** [ ] Hispanic or Latino [ ] Not Hispanic or Latina [ ] Other _____

**Language:** [ ] English [ ] Spanish [ ] Other _____

**Email:** _____

**Street:** _____Apt. _____PO Box: _____

**City:** _____ State: _____ Zip: _____

**Contact info:** Main Ph: _____-_____-_____ Cell Ph: _____-_____-_____ Other Ph: _____-_____-_____

**Occupation:** _____ Employer: _____

**Employer Address:** _____

Street City State Zip

**Emergency Contact:** Name: _____ Relationship: _____ Phone: _____-_____-_____

## Patient History

**Please give a brief description of the problem[s] you are experiencing:** _____

_____

_____

_____

**Is/Are the problem[s] getting better?**: [ ]Y [ ] N When did problem[s] start? _____

Are you seeing any other providers for this or other problems or health conditions? [ ] Y [ ] N

If yes please list provider, problem[s] or condition[s]: _____

_____

_____

Have you ever been to a chiropractor before? [ ] Y [ ] N If yes, how long ago?: _____

**Females Only:** Are you pregnant? [ ] Y [ ] N If yes, how far? _____ Please Initial: _____

**Past History**

Have you ……. If yes, listdate and treating provider (as close as possible.)

ever been diagnosed with hypertension? [ ] Y [ ] N _____

been hospitalized in the last 5 years? [ ] Y [ ] N _____

been diagnosed with Diabetes? [ ] Y [ ] N _____

[ ] Type I [ ] Type II

Do you smoke? [ ] Y [ ] N Do you drink alcohol? [ ] Y [ ] N Do you exercise? [ ] Y [ ] N Do you drink caffeine? [ ] Y [ ] N

Please list all medication (prescription and non-prescription), if you have a list we can just make a copy of that. _____

_____

_____

_____

Do you have allergies? [ ] Food [ ] Enviromental [ ] Medication List type of allergy[s] and reaction[s]: _____

_____

_____

_____

## AUTHORIZATIONS AND RELEASES

**Permission to Treat if a minor: Signature of Parent or Guardian: _____**

**X-rays:** I understand that Clinton Chiropractic Center is submitting my x-rays to an independent radiologist for review. I authorize the release of medical information so that we can bill your insurance if applicable. I also assign benefits for this service to the Clinton Chiropractic Center and understand that I am responsible for any unpaid balance due.

**Medicare Patients Only: I understand that Medicare does not cover this service, but my supplemental insurance will be billed if applicable. PLEASE initial: _____**

**Permission to Discuss:** I give my permission for Dr. Stephanie Cluver and the staff of the Clinton Chiropractic Center to discuss my condition and financial concerns with:

1_____ Relationship _____

2_____ Relationship _____

3_____ Relationship _____

**Privacy Notice:** I understand that “upon request” I will be provided with a "*Notice of Information Practices*" that provides a more complete description of information uses and disclosures.

**Patient's (or person responsible if a minor) Signature: _____**

# Financial Policy

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I hereby authorize the assignment of my benefits to be paid directly to the Clinton Chiropractic Center. I realize I am financially responsible for all non-covered services, and that the fees of these services are subject to change at any time. I authorize the doctor to release any information requested for payment. Furthermore I understand that the doctor shall have the right as her option to collect a delinquent charge, interest, and/or accelerate the maturity of the total of payments. It is my responsibility to pay all attorney fees, court, and/or collection cost and disbursements made to collect this account. Any amount remaining unpaid after the expiration of the maturity date shall draw interest at the highest allowable rate in the state of Illinois. Patient authorizes the Clinton Chiropractic Center to deposit checks received on patient's account when made out to the patient.

**Medicare Patients Only**

**I understand that Clinton Chiropractic Center does not accept assignment of Medicare, but we will bill all services and any money paid will be sent directly to me. Therefore, I realize I am financially responsible for all services, and that the fees of these services are subject to change at any time.** **Please Initial: _____**

Patient authorizes EFT (Electronic Funds Transfer) of delinquent accounts up to account balance, in the event of default. Please choose either of the options below:

Debit or Credit Card, please provide the following:

☐ MasterCard ☐ Visa ☐ Discover

Name on Card: _____

Card number: _____

Security Code: _____

Expiration Date: _____

Bank Account, please provide the following:

☐ Checking ☐ Savings

Name on Account: _____

Name of Bank: _____

Routing number: _____

Account number: _____

**Signature: _____ Date: _____**