JERSEY CITY CHIROPRACTIC & ACUPUNCTURE

Dr. Dominique Bariso, DC, LAc & Dr. Maria Crincoli, DC
944 Westside Avenue, Jersey City, NJ 07306
Tel: 201-432-3693 Fax: 201-432-3896

NEW PATIENT INTAKE FORM

Patient Information

Full Name: _____ Date: _____
First MI Last

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

Age: _____ Birth Date: _____/_____/_____ Gender: (circle) Female / Male / Other

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I am (circle) Under Age18 / Single / Married / Divorced / Widowed / Separated

Employer: _____ Occupation: _____

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

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.	

How did you hear about us? □ Website □ Public Event □ Referred by _____

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Reason for today's visit:

Describe the reason(s) for your visit today:

_____

_____

Are you here because of an accident? _____ If so please describe: _____

When and how did your symptoms start?_____

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***

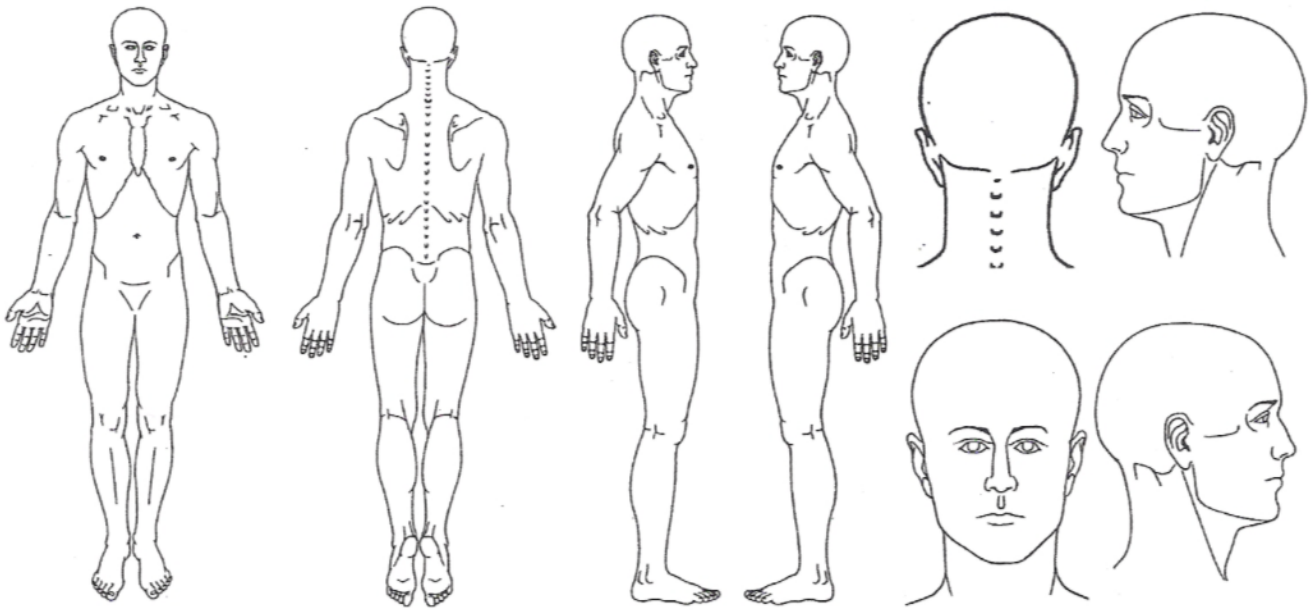
Do your symptoms interfere with any of the following? *(circle all that apply)* ***Work*** ***Sleep*** ***Daily Activities***

Have you experienced these symptoms in the past?_____

Have you seen another doctor or healthcare provider for these symptoms?_____

Have you seen a chiropractor before? □ Yes □ No Have you seen an acupuncturist before? □ Yes □ No

Mark any area(s) of discomfort with the following key: ***A =Ache*** ***N =Numbness*** ***B = Burning*** ***T = Tingling*** ***S = Stiffness*** ***O = Other***



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HEALTH QUESTIONNAIRE

Height: _____ Weight: _____

Medications: *list all prescription or non-prescription medications, vitamins, or herbs you take, list dosage, and for what condition*

_____

_____

_____

Surgeries or hospitalization: *list any surgeries or hospitalizations and the date of each*

_____

_____

_____

Allergies: *list anything you are allergic to* _____

Family History: *list all major diseases (CANCER, DIABETES, HEART DISEASE) and the relation of the individual to you*

_____

_____

_____

Do you exercise? □ Yes □ No Hours per week _____ What activity(s) _____

Are you dieting? □ Yes □ No What is your typical diet like? _____

Do you smoke currently? □ Yes □ No Did you smoke in the past? □ Yes □ No _____ packs per day for _____ years

Do you drink alcoholic beverages? □ Yes □ No Did you drink in the past? □ Yes □ No _____ drinks per day for _____ years

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For Women: Are you pregnant or nursing? □ Yes, _____ weeks □ No # of pregnancies _____ # of children _____

Additional comments you would like the doctor to know regarding your health: _____

_____

Primary care physician: _____ Date last seen: _____

May we update them on your condition? □ Yes □ No

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For the conditions below please mark if you experience any of the following:

1 if you CURRENTLY HAVE these symptoms
2 if you PREVIOUSLY HAD these symptoms

MUSCULO-SKELETAL

_____ Neck Pain
_____ Shoulder Pain/upper arm pain
_____ Elbow/forearm pain
_____ Wrist/hand pain
_____ Upper Back Pain
_____ Mid Back Pain
_____ Lower Back Pain
_____ Hip/upper leg pain
_____ Knee pain/lower leg pain
_____ Ankle/Foot pain
_____ Joint swelling/stiffness
_____ Weak muscles
_____ Difficulty walking
_____ Tendon ruptures
_____ Broken bones
_____ Arthritis
_____ Gout

NERVOUS

_____ Numbness/tingling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Epilepsy/Convulsions/Seizures
_____ Confusion

GASTRO-INTESTINAL

_____ Excessive hunger
_____ Excessive thirst
_____ Nausea/Vomiting
_____ Vomiting blood
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids/rectal bleeding
_____ Hepatitis or Liver disease
_____ Gall stones or gallbladder infection
_____ Diabetes
_____ Abdominal pain
_____ Ulcer

GENITO-URINARY

_____ Bladder infection
_____ Kidney infection
_____ Kidney stones
_____ Pain or difficulty with urination
_____ Scanty or Infrequent urination
_____ Excessive or Frequent urination
_____ Discoloration of urine or blood in urine
_____ Loss of bladder control
_____ Retention of urine
_____ STD's
_____ Prostate problems
_____ Abnormal vaginal bleeding

CARDIO-VASCULAR/RESPIRATORY

_____ Chest pain/angina
_____ Heart attack
_____ Stroke
_____ Rapid heart beat
_____ High/low blood pressure
_____ Heart problems
_____ Difficulty breathing/Shortness of breath
_____ Persistent cough
_____ Coughing up blood
_____ Lung problems
_____ Asthma / Bronchitis / COPD / Emphysema
_____ Swelling in legs
_____ Bleeding disorders
_____ Circulation disorders

EYE, EAR, NOSE, THROAT

_____ Vision problems/changes
_____ Ringing in ears
_____ Hearing loss
_____ Frequent nosebleeds
_____ Sinus problems
_____ Hoarseness
_____ Difficulty speaking or swallowing

OTHER

_____ Depression
_____ Unexpected weight gain/loss
_____ General fatigue
_____ Allergies
_____ Insomnia
_____ Thyroid disorder
_____ Cancer
_____ HIV/AIDS
_____ Hormone Therapy
_____ Lupus
_____ Autoimmune conditions
_____ Skin conditions
_____ Mental or emotional disorders

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or staff responsible for any errors or omissions that I may have made in the completion of this form.

Signed _____ Date _____

Consent for Examination

By signing below, I give my consent for examination and the performance of 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 _____

Authorization for Contact

By signing below, I authorize Jersey City Chiropractic (JCC) to use my name, address, telephone number, and/or email address to contact me regarding appointments, newsletters, products, and events. The use of this information is intended to make my experience with JCC more efficient, productive, and to further enhance my access to quality health care. If I choose not to authorize this information use, my decision will have no adverse effect on my care or my relationship with the staff at Jersey City Chiropractic. My authorization may be revoked at anytime via writing.

Signed _____ Date _____

Financial Policy

CHIROPRACTIC CARE:

Regarding ALL insurance: *We accept insurance for chiropractic care and will bill your insurance carrier. We strongly suggest you contact your insurance carrier to verify your benefits. Payment of non-covered services and co-payments is expected at time of service. If your insurance carrier fails to pay for services within ninety days, you are responsible for payment and any outstanding balances.*

Regarding Medicare: *Medicare pays for a limited portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include an initial exam, other therapies, services, and goods that may be necessary during care. Payment for non-reimbursable care is your responsibility.*

Regarding Personal Injury, Worker's Compensation, or Litigation: *If an attorney is involved, you are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within 14 days, the fee for all services rendered is your responsibility.*

ACUPUNCTURE CARE: *Most insurance companies do not cover acupuncture, however if yours does, we will gladly bill your carrier. We strongly suggest you contact your insurance carrier to verify your benefits. If your insurance carrier fails to pay for services within ninety days, you are responsible for payment and any outstanding balances. If your insurance does not cover acupuncture, you are responsible for payment at time of service.*

For those without insurance: *We accept cash, checks, and credit/debit cards. Payment is expected at time of service.*

By signing below, I understand the financial policy, and that I am financially responsible for all unpaid balances for my care.

Signed _____ Date _____

Assignment of Benefits & Release

By signing below, I authorize Jersey City Chiropractic (JCC) to release medical records required by my insurance company(s). I authorize my insurance company to pay benefits directly to JCC and I agree that a reproduced copy of this authorization will be as valid as the original. I agree that I will be responsible for any collection agency or attorney fees incurred.

Signed _____ Date _____