PATIENT INTAKE FORM

Dr. Corinne A Kennedy of Kennedy Chiropractic Center

11515 W. North Avenue -Ste. A- Wauwatosa WI 53226

414-443-1515

Office Use Only

Patient #:_____

Patient Name:_____**Date:**_____/_____/_____
First Middle Last

Sex: ☐ **Male** ☐ **Female** **Birthday:**_____/_____/_____ **Age:**_____ **Social Security Number:**_____

Address:_____

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

Cell Number: (_____**)** _____ **Home Number: (**_____**)** _____

E-Mail:_____**@**_____

EMERGENCY CONTACT:_____**PHONE #: (**_____**)**_____**RELATION:**_____

☐ **Married** ☐ **Single** ☐ **Widow** ☐ **Minor** ☐ **Separated** ☐ **Divorced** ☐ **Partnered**_____**Years**

☐ **Employed** ☐ **Full-Time Student** ☐ **Part-Time Student** ☐ **Retired** ☐ **Other**_____

Whom Can We Thank For Your Referral?_____

EMPLOYMENT/SCHOOL INFORMATION

Patient Employer/School:_____**Occupation:**_____

Employer/School Address:_____**Phone: (**_____**)**_____

INSURANCE INFORMATION

Primary Insurance Company:_____

ID #:_____**Group #:**_____

Secondary Insurance Company:_____

ID #:_____**Group #:**_____

If your insurance is provided through your spouse, parent, guardian, etc., please complete below:

Insurance: ☐ **Primary** ☐ **Secondary**

Responsible Party's Name:_____

Responsible Party's Date of Birth:_____/_____/_____

Relationship to Responsible Party:_____

Responsible Party's Employer_____

Kennedy Chiropractic Center Will Provide A Complimentary Insurance Check At Your Request

PATIENT INSURANCE RESPONSIBILITIES

Dr. Corinne A. Kennedy of Kennedy Chiropractic Center
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The purpose of Chiropractic services is to promote health naturally, through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict a time schedule or effectiveness of Chiropractic procedures. Sometimes the response is immediate, but in most cases, gradual. Occasionally, the results are longer than expected. There may be more than one condition to work on, therefore, care may vary in length of time.

As a patient of KCC, you are giving the doctor permission and authority to care for yourself or a minor in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course will not give a Chiropractic adjustment, or health care, if she feels the treatment may be contraindicated. It is the responsibility of the patient to make sure it is known or to learn through health care procedures whatever he/she is suffering from, be it latent pathological defects, illness, or deformities which would otherwise not come to the attention of Dr. Kennedy.

In some cases, KCC fees are not covered, in full, by your insurance company. We want our patients to be aware of the fact that under any circumstances, the patient is personally responsible for any balance due after insurance has paid. KCC expects full payment within 30 days upon receipt of your statement. Any unpaid balance after 30 days will be charged a 1.5% monthly interest fee until all unpaid balances are paid in full. This balance due including provisions set by your insurance company, such as co-payments, co-insurances, deductibles and “usual and customary” allowances. The policy held by you or your employer is a contract between the policy holder and the insurance company. KCC does not accept insurance companies as patients; you are the patient. As the patient, you understand that you are financially responsible for all charges, whether paid by the insurance company or not. If you are unfamiliar with your insurance coverage, we ask that you discuss this with your employer or your insurance company before any charges are incurred. If your insurance requires any specific forms please bring those to our attention so that we can submit them prior to your care. It is always best for you to understand your coverage before beginning treatment, so you know what you are responsible for. We will do a complimentary benefits check for you, however, this is only an estimate of coverage and not a guarantee of payment. Your policy always rules as it applies on the day of service.

I consent to allow Kennedy Chiropractic Center to use and or disclose my Protected Health Information in compliance with their policy as indicated in their Notice of Patient Privacy Practices. My signature allows KCC to use my personal information for insurance purposes, including an assignment of benefits.

X_____Date:_____/_____/_____

OTHER PATIENT RESPONSIBILITIES

In order to provide you and other patients with optimal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Kennedy Chiropractic Center asks that you give us a 24 hour notice if you need to cancel or change your scheduled appointment time. If we do not receive sufficient notice or you do not show for your appointment, you will be charged a $10 fee before rescheduling your next appointment. In the hope of maintaining good, open communication and understanding between you and Dr. Kennedy. If you have any questions, please ask Dr. Kennedy or the front desk staff member.

X_____Date:____/_____/_____

I acknowledge that I have seen, and been offered a copy of the Kennedy Chiropractic Center **Notice of Privacy Practices**, and been given an opportunity to review and understand it. The notice brochure describes the types of uses and disclosures of my **Protected Health Information** that might occur in my treatment, payment of my bills or in the performance of health care operations. The notice brochure also describes my rights and duties of KCC with respect to my **Protected Health Information.**

X_____Date:_____/_____/_____

I give permission for my **Personal Health Information** to be released to the following people upon their request.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

X_____Date:____/_____/_____

CONFIDENTIAL HEALTH QUESTIONNAIRE— PRESENT HISTORY

Dr. Corinne A. Kennedy of Kennedy Chiropractic Center
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1. **Reason For Visit:**_____
2. **Describe Current Symptoms:**_____
3. **Date Symptoms Began:**_____**Related To:** ☐ **Work Injury** ☐ **Auto Accident** ☐ **Other** _____
4. **Describe How Your Symptoms Began:**_____

_____

5. How Often Do You Experience Your Symptoms:

- ☐ **Constantly (76-100% of the day)**
- ☐ **Frequently (51-75% of the day)**
- ☐ **Intermittently (26-50% of the day)**
- ☐ **Occasionally (0-25% of the day)**

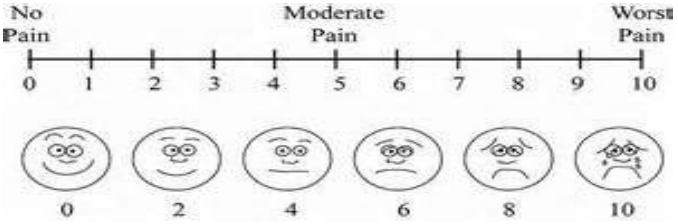
6. Type Of Pain Felt:

- ☐ **Sharp**
- ☐ **Dull Ache**
- ☐ **Numbness**
- ☐ **Throbbing**
- ☐ **Shooting**
- ☐ **Burning**
- ☐ **Tingling**
- ☐ **Stiffness**

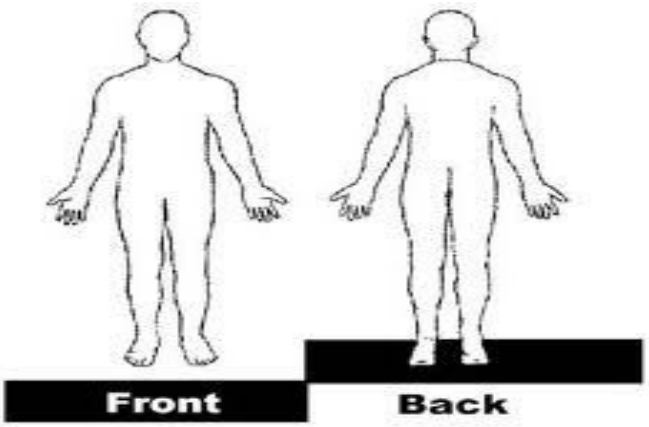
7. Does Your Pain Interfere With:

- ☐ **Work**
- ☐ **Daily Routine**
- ☐ **Driving**
- ☐ **Standing**
- ☐ **Bending**
- ☐ **Sleep**
- ☐ **Sitting**
- ☐ **Walking**

8. Please Rate Your Pain On A Scale From 1-10



Please Indicate Where You Have Pain Or Other Symptoms



9. How Are Your Symptoms Changing?

- ☐ **Getting Better**
- ☐ **Not Changing**
- ☐ **Getting Worse**

10. What Is Your Occupation?_____**Stress Level (1-10)**_____

11. Do You Smoke?_____**Do You Drink Alcohol?**_____

12. Have You Had Similar Symptoms In The Past? (If Yes, Explain)_____

13. Have You Seen Any Health Care Professionals For Your Current Symptoms? (If Yes, What Was The Treatment Plan)_____

_____

14. Have You Had Any Tests Performed For Your Current Symptoms?_____

15. Are You Currently Taking Any Medication/Vitamins? (If Yes, Please List)_____

_____

16. Do You Have Any Allergies? (If Yes, Please List)_____

17. Are You Currently Pregnant?_____**Date Due:**_____

CONFIDENTIAL HEALTH QUESTIONNAIRE—PAST HISTORY

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1. **Date Of Last Physical Exam?_____/_____/_____ Spinal X-ray?_____/_____/_____ Blood Test?_____/_____/_____**
2. **Have You Had Any Surgeries?_____When?_____/_____/_____**
3. **Have You Had Any Serious Illnesses Or Conditions ?_____When?_____/_____/_____**
4. **Have You Been Treated By A Physician For Any Health Condition In The Past Year?_____When?_____/_____/_____**
5. **Have You Had Any Serious Falls?_____ When?_____/_____/_____**
6. **Have You Had Any Head Injuries?_____ When?_____/_____/_____**
7. **Have You Had Any Broken Bones?_____When?_____/_____/_____**

Please Circle All Symptoms You Have Had In The Last 6 Months

Alcoholism	**Emphysema**	**Multiple Sclerosis**	**Thyroid Disease**
Allergy Shots	**Epilepsy**	**Nervousness/Anxiety**	**Tuberculosis**
Anemia	**Fractures**	**Numbness**	**Ulcers**
Anorexia	**Glaucoma**	**Osteoporosis**	
Appendicitis	**Gout**	**Pacemaker/Defibrillator**	
Arthritis	**Headaches**	**Parkinson's Disease**	
Asthma	**Heart Disease**	**Pinched Nerve**	
Backaches	**Hepatitis**	**Pneumonia**	
Bleeding Disorder	**Herniated Disc**	**Polio**	
Cancer	**High Cholesterol**	**Prostate Issue**	
Cataracts	**Kidney Disease**	**Prosthesis**	
Chemical Dependency	**Liver Disease**	**Psychiatric Care**	
Chicken Pox	**Measles**	**Rheumatoid Arthritis**	
Depression	**Migraine**	**Scarlet Fever**	
Diabetes	**Miscarriage**	**Sinus Issue**	
Dizziness	**Mononucleosis**	**Stroke**	

Automobile Accident History Form

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PLEASE CIRCLE ALL THAT APPLY

Date Of Accident:_____/_____/_____ Time Of Accident: _____:_____am/pm Daylight Dawn Dusk Dark

Road Conditions At The Time Of The Accident: Wet Dry Snow Ice Other_____

Was The Accident On The Job? Yes No Were You In A Company Vehicle? Yes No

Where Were You Seated In The Vehicle? Driver Passenger Rear-Seat Other_____

Were You Aware Of The Approaching Collision Prior To Impact, Or Did It Catch You By Surprise? Aware Surprise

Did You Loose Consciousness Upon Impact? Yes No

What Were Your Initial Symptoms? None - Headache - Dizzy - Disoriented - Shock - Neck Pain -Back Pain -Other_____

What Were Your Symptoms The Next Day?_____

Have You Been In Any Prior Accidents? (If Yes, Please Explain)_____

Did The Police Come To The Accident Scene? Yes No

PLEASE CIRCLE ALL THAT APPLY

Were You Wearing A Seatbelt? Yes No If Yes, Did You Receive Any Injury Or Bruising From Seatbelt? Yes No

Did Your Head Hit The Headrest During Impact? Yes No Was The Position Of The Headrest Altered? Yes No

Was The Seat Adjustment Altered During Impact? Yes No Was The Seat Broken During The Accident? Yes No

Did The Air Bag Deploy? Yes No If Yes, Did It Strike You? Yes No If Yes, Where?_____

Which Way Was Your Head Pointing At The Time Of Impact? Straight Right Left / Your Body? Straight Right Left

Where Were Your Hands? One On The Wheel Both On The Wheel Does Not Apply

Were You Wearing Glasses Or A Hat At The Time Of Impact? Yes No If Yes, Were They Still On After The Accident? Yes No

PLEASE CIRCLE ALL THAT APPLY

Did You Go To The Hospital? Yes No When? Immediately Hours Later Days Later Which Hospital?_____

How Did You Get To The Hospital?_____ Were You Admitted? Yes No

What Were The Hospitals Findings?_____

YOUR CAR

List The Year, Make And Model Of The Car You Were In: Year_____Make_____Model_____

Was Your Car Stopped At The Time Of Impact? Yes No If Yes, Was The Drivers Foot On The Brake Yes No

Was Your Vehicle Moving At The Time Of Impact? Yes No If Yes, At Approximately What Speed_____MPH

OTHER CAR

List The Year, Make And Model Of The Other Car: Year_____Make_____Model_____

Was The Other Car Moving At The Time Of Impact? Yes No If Yes, At Approximately What Speed?_____MPH

At The Time Of Impact, Was The Other Care: Slowing Down Gaining Speed Steady Speed

Please Describe, To The Best Of Your Knowledge, What Happened During This Accident

_____

_____

_____

_____

_____

You May Draw The Accident Here

AUTOMOBILE ACCIDENT COVERAGE INFORMATION

AUTOMOBILE INSURANCE INFORMATION

Name Of Driver Of The Car You Were In:_____

Name Of Their Auto Insurance:_____

Policy #:_____**Claim #:**_____

Auto Insurance Phone #: _____/_____/_____**Name Of Insurance Adjuster:**_____

Name Of Driver Of The Other Vehicle:_____

Name Of Their Auto Insurance:_____

Policy #:_____**Claim #:**_____

Auto Insurance Phone #:_____/_____/_____**Name Of Insurance Adjuster:**_____

Have You Retained An Attorney? If Yes, Provide Name And Phone#:_____

NON RESCINDABLE AGREEMENT LETTER

This agreement is between Dr. Corinne A Kennedy and_____

And any third party involved in the accident on _____

I_____**do hereby authorize and agree to pay any outstanding balance due on my account at the time of my release from care.**

I do instruct any monies due from my personal injury protection to be paid directly to Dr. Corinne A Kennedy.

I instruct my attorney to pay in full any outstanding monies due to Dr. Kennedy at that time of my settlement with any liability claims that result from the case. My attorney shall NOT withhold any portion of the amount due to Dr. Kennedy under this agreement to offset attorney's fees, which my attorney now or hereafter may claim to be owed by me. I instruct my attorney to pay Dr. Kennedy immediately upon settlement, by was of issuance of a separate draft made payable to Kennedy Chiropractic Center.

I instruct any third party individual or insurance carrier that may be liable, to pay Dr. Corinne A Kennedy direct for any out-standing medical bills which are the result of this accident. If payment is not made until time of settlement, I instruct the third party to issue a separate draft to be payable to Kennedy Chiropractic Center.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to Dr. Corinne A Kennedy's right to collect payment. I understand that Dr. Corinne A Kennedy has the right to expect good faith payments on my account and that a full payment in being deferred only until such time as a third party settlement occurs. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

Patients Signature:_____ **Date:** _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF AGREEMENT

As the insurance adjuster, or attorney, on this claim, I acknowledge that I have received notice of the patient's agreement and will abide as instructed.

Adjuster/Attorney Signature:_____**Date:**_____/_____/_____