Dixon Center for Integrative Health Care
211 Old Hickory Blvd
Nashville, TN 37221
(615) 646-1003

Patient Intake Form

Please update the following information *in full* and provide us with a Photo ID.

Have you ever received chiropractic care? □ Yes □ No Whom may we thank for referring you?_____

PATIENT INFORMATION

Full Legal Name:_____ Nickname/Preference:_____

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

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-mail address _____

Sex: □ Male □ Female Best Number to reach you during day: □ Home □ Cell □ Work

Race: □ American Indian □ Alaska Native □ Asian □ African American □ Native Hawaiian □ Caucasian □ Other □ Declined to State

Ethnicity: □ Declined to State □ Hispanic or Latino □ Not Hispanic or Latino

Marital Status: □ Married □ Single □ Divorced □ Widowed

Appointment Reminder Notification Method: □ None □ Home Phone □ Cell Phone □ Text Message □ E-mail

Date of Birth:_____ Social Security Number:_____ Preferred Language:_____

Employer:_____ Occupation:_____

Spouse Name:_____ Spouse Employer/Occupation:_____

Emergency Contact Name:_____ Phone:_____

Primary Care Physician (PCP):_____ Phone:_____

Account/Case Type: □ Self-Pay/Cash □ Insurance □ Personal Injury □ Workers' Compensation

If you chose Insurance, we need the information for the account holder. A dependents information for this field is not acceptable.

Insurance Company:_____ Primary Subscriber's Name:_____

Primary Subscriber's Date of Birth:_____ Primary Subscriber's ID/Group Number:_____

I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. I agree to pay all balances over 90 days from the original due date, as well as court costs and reasonable collection and attorneys' fees, with or without suit, incurred in collecting any past due balance. I certify that the information I am providing is correct to the best of my knowledge. I will not hold my doctor, provider or any other staff member responsible for errors or omissions that I may have made in the completion of this form. I hereby authorize Dixon Center for Integrative Health Care (and whoever may be designated as assistants) to administer such examination and treatment as they deem necessary.

Patient Name Signature Date

_____

Witness

PERSONAL HISTORY

1. What are you being seen for today?_____
2. How long have you had symptoms?_____
3. What are your symptoms?_____
4. What makes your symptoms worse?_____
5. What makes your symptoms better?_____
6. What previous treatment have you had?_____
7. What may have caused your symptoms?_____

MEDICAL HISTORY

1. Do you smoke? □ Yes □ No --- If Yes, How much?_____
2. Have you ever smoked? □ Yes □ No --- If Yes, How much?_____
3. Do you drink? □ Yes □ No --- If Yes, How much?_____
4. Current Medications/Supplements/Vitamins:_____

   _____
5. Surgical History (Please Include Year):_____

   _____
6. Allergies (Drug/Food/Environmental/Chemical):_____

   _____
7. Check all that apply regarding your personal and family history in the below chart. **If the condition applies to a family member, please write which family member in which it applies to**.

Condition	You	Family	Condition	You	Family	Condition	You	Family
Acid Reflux/GERD			Headaches/Migraines			Osteoarthritis		
Alcoholism			Heart Attack			Osteoporosis		
Aneurysm			Hepatitis			Rheumatoid Arthritis		
Anxiety			High Blood Pressure			Seasonal Allergies		
Asthma			High Cholesterol			Seizures		
Blood Clots			Kidney Disease			Sleep Apnea		
Cancer			Kidney Stones			STD/HIV		
Depression			Liver Problems			Stroke		
Emphysema/COPD			Lupus			Substance Abuse		
Gout			Obesity			Thyroid Problems		

8. Complete the chart below as it relates to screening/prevention:

Screening/Prevention Test	Year	Screening/Prevention Test	Year	Screening/Prevention Test	Year
Cholesterol Check		Physical Exam		For Women: Bone Density Test	
Colonoscopy		Pneumonia Vaccine		For Women: Mammogram	
Diabetes Check		Tetanus Shot		For Women: Pap Smear	
Flu Vaccine		For Men: Prostate Exam			

9. Please complete the following information if you have or have had any symptoms in the past year:

Body System	Symptoms
Dermatology/Skin (Example: Eczema, Rash, Irregular Moles, Discolored Skin)	
Head, Ears, Nose, Throat (Example: Ear Ringing, Sinus Issues, Mouth Sores)	
Cardiovascular (Example: Chest Pain, Heart Problems, Fainting)	
Respiratory (Example: Wheezing, Shortness of Breath, Snoring)	
Gastrointestinal (Example: Stomach Pain, Nausea, Vomiting, Constipation)	
Genitourinary (Example: Kidney/Bladder Infections, Pain with Urination)	
Lymphatic/Hematologic (Example: Easy Bruising, Easy Bleeding, Swollen Glands)	
Musculoskeletal (Example: Swollen Joints, Muscle Spasms, Muscle Cramps)	
Endocrine (Example: Thyroid Problems, Diabetes)	
Psychiatric/Neurological (Example: Headaches, Dizziness, Tremors, Poor Balance)	
Female/Male Specific (Example: Irregular Periods, Pregnancy/Prostate Problems)	
Other	

OUR OFFICE POLICIES

Our goal is to provide and maintain a good physician-patient relationship. By informing you in advanced of some of our policies, it allows for good communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, please do not hesitate to ask a member of our staff.

HIPAA POLICY:

1. We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.
2. Your health care provider and members of the staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you.
3. You may restrict the individuals to which your health care information is released. Please complete the below chart as to whom you authorize to receive your health information:

    1. Name:_____ Relationship:_____ Telephone Number:_____
    2. Name:_____ Relationship:_____ Telephone Number:_____
    3. Name:_____ Relationship:_____ Telephone Number:_____

    The following information may be disclosed to the above mentioned name(s) (Please check all that apply):
    □ All Information □ Results Only □ Appointment Status

    Protected Health Information may be disclosed via (Please check all that apply):
    □ Home Voicemail □ Mobile Voicemail □ Work Voicemail □ Email

APPOINTMENTS:

1. We value the time we have set aside to see and treat you. If you are not able to keep a chiropractic appointment we would appreciate notice as soon as possible.
2. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We require 24 hour notice for cancelling massage, acupuncture, medical, or weight loss appointments. A $25 fee will be charged for these missed appointments.

INSURANCE PLANS:

1. It is your responsibility to keep our office updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
2. It is your responsibility to understand your benefit plan with regard to, for instance:
    a. If a written referral or authorization is required to see specialists or if preauthorization is required prior to a procedure.
    b. Some charges may or may not be covered. While the filing of insurance claims is a courtesy that we extend to our patients, not all plans cover all services performed in a chiropractic/medical office. All charges not covered by your plan are your responsibility.

FINANCIAL RESPONSIBILITY:

1. Payment is required at the time of service. We accept cash, check, or credit card (Visa or MasterCard).
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. Financing is available with Care Credit for those who qualify.
4. If we do not participate with your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5. Self-pay patients must pay at the time of service in full. Standard rates will apply unless the patient enrolls with the discount medical plan organization (ChiroHealth USA) which legally entitles patients to cash discounts.
6. General benefit verification will be provided on the second visit as a courtesy to patients, however this is not a guarantee of payment and final determination will be applied off the explanation of benefits.
7. For scheduled appointments, prior balances must be paid prior to the visit.
8. Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may incur additional fees.
9. There is a service charge of $20 for returned checks.
10. Please call or email if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
11. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent you from receiving care you need.
12. Refunds are only provided after all outstanding claims have been processed by the insurance company for services rendered and after patient liability has been accounted for. If a true credit remains after this point, the patient is entitled to have their credit returned within 5 days via check or keep it on file to go towards future visits.
13. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.

MEDICAL RECORDS/X-RAYS:

1. Advanced notice is required for x-ray requests (typically 3-5 business days). Original copies of x-rays may be signed out but must be returned no later than 30 business days.
2. If you transfer to another physician, we will provide a copy of your medical record, free of charge, as a courtesy to you. We need 48 hours' notice.

I understand the above information and guarantee this form was completed to the best of my knowledge.

Patient Name Signature Date

_____

Witness