ADVANCED CHIROPRACTIC OF PHILADELPHIA
CLIENT INTAKE

PATIENT INFORMATION							
Preferred First Name:		Last Name:			Middle Initial:	Today's Date:	
Date of Birth:	Does the name above match what's on your insurance card? Yes No (If no, please write name that matches)				Gender Identity:	Preferred Pronouns:	
Mailing Address:		City:		State:	Zip:		
Email Address:		Home Phone:		Cell Phone:			
Social Security Number (Optional):	Marital Status: S M DP D SEP		Partner's Name:				
Occupation:		Employer:			Work Phone:		
Known Allergies, if any:			Do you smoke? Yes No	How often?			
Height:	Weight:	How did you hear about us?					

EMERGENCY CONTACT	
In the event of an emergency, who would you like us to contact about your care?	What is the best phone number to reach this person?

INSURANCE INFORMATION		
Primary Insurance Company:	Member ID:	Group Number:
Policy Holder's Name:	Date of Birth:	Relationship to policy holder?
Address, if different from above:	City:	State: Zip:

ADMINISTRATIVE CHECK LIST (Please leave blank for office use)								
Patient Info Complete:	Y N	Initial	Insurance Info Complete:	Y N	Initial	Card Copied:	Y N	Initial
Emergency Contact Listed:	Y N	Initial	Added to Mailing list:			Y N	Initial	
Notes:								

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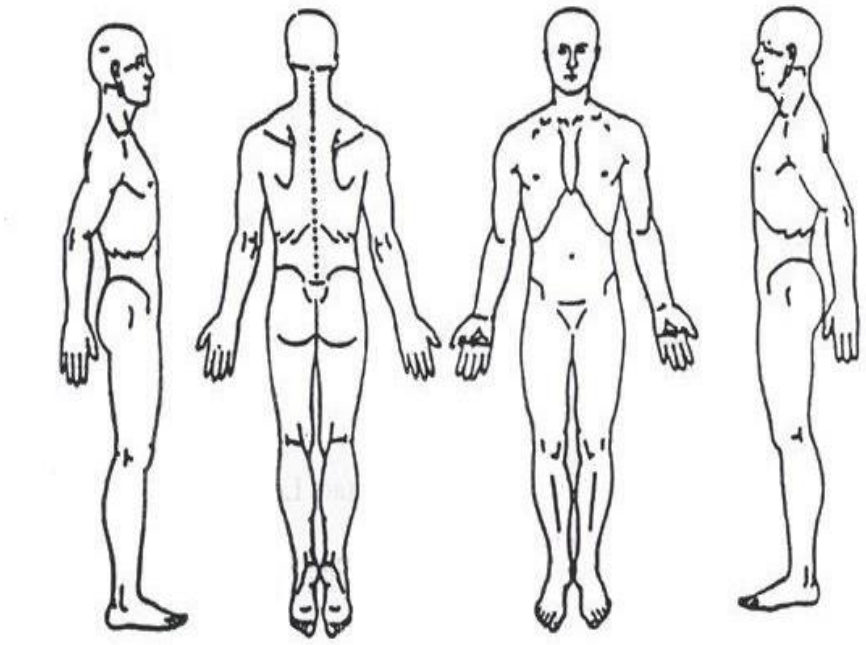
WHAT BRINGS YOU TO OUR OFFICE TODAY?			
Please describe your primary complaint and the symptoms you experience, including when it began:			
Which words best describe your pain? Sudden Gradual Progressive Sharp (Circle all that apply) Dull Ache Burn Throb			
What makes your symptoms increase?		What relieves your symptoms?	
Do you experience numbness? Yes No	Where?	Do you experience tingling? Yes No	Where?
How often do you experience your symptoms? (Circle one) 100% 75% 50% 25% 10%			
On the scale below, please mark a line that best describes the intensity of your pain: No Pain _____Unbearable Pain			
What, if any, medications are you taking for your condition and how much?			
Have you been in any accidents (car or otherwise)? Yes No		When?	
Have you previously sought treatment for your condition? Yes No	When?	Please describe:	
If you've had any related surgeries, what type and when?			

On the body maps to the right, please shade the areas where you are experiencing pain.



PATIENT SIGNATURE
By signing below, I certify that my personal information and my medical history written above are true and correct to the best of my knowledge.
_____ Signature _____ Date

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Statement of Privacy

At Advanced Chiropractic of Philadelphia, we value your privacy and we strive to protect your confidential personal and medical information. **We are required by law to provide you notice of your patient rights, our legal obligations and our privacy practices with respect to the information you entrust to us.**
Throughout the course of your care with Dr. Alexander Jamieson, we may use and/or disclose personal and medical information about you in the following ways:

- **For Treatment**: We may use or disclose your personal and medical information, including clinical records, to another health care professional or medical practice if it is necessary to seek consult or refer you for further diagnosis or treatment.
- **For Payment**: We may use or disclose your personal and medical information, along with billing records, to your insurance provider (including your Employer/Human Resources) for the purpose of benefits assessment, payment requirements, or related health insurance operations.
- **For Health Care Operations**: We may use or disclose your personal and medical information to a third party for the following reasons
    - As required by law enforcement officials or in legal proceedings. (For example, by court order, subpoena, or to comply with such an investigation.)
    - To worker's compensation or similar programs in order to process claims.
    - If we provide health care services to you in an emergency situation.
    - Other uses and disclosures as required by local, state, and federal law.
- **For Marketing**: *We will never use or disclose your **medical information** for marketing purposes.* We may use or disclose your personal information for the purpose of appointment correspondences, such as leaving voicemail messages at the phone numbers you provide. We may also use or disclose your personal information to provide care alternatives and / or to suggest health-related information that may be of interest to you via our email newsletter/s.

You have the right to obtain a copy of all personal and medical information in your patient file, including a print copy of this privacy statement. You have the right to refuse authorization of this office to disclose your personal or medical information. You have the right to request a limitation on the use or disclosure of your personal or medical information. You have the right to amend the personal and medical information you provide to us. You have the right to register a complaint regarding our privacy statement, use and disclosure practices, to request further information. All questions or complaints should be directed *in writing* to Dr. Alexander Jamieson of Advanced Chiropractic of Philadelphia. You may also file a complaint at: www.HHS.gov/ocr/HIPPA

*Any request, amendment or refusal must be rendered **in writing** to Advanced Chiropractic of Philadelphia.* We reserve the right to dispute any request, amendment or refusal. Use or disclosure of your personal and medical information, other than as outlined above, will be made only upon written authorization. Further, we maintain information about your personal and medical information for seven (7) years from the date of your first appointment, or as long as the information remains in our files.

This notice is effective as of January 3, 2018. This notice and any alteration or amendments made hereto will expire seven (7) years from the date of your first appointment or from the date upon which your client file was first created in our medical records system.

My signature acknowledges that I have read this notice and received a copy for my records as per request.

Name (Print):_____

Signature:_____ Date:_____