



## ATLANTIC CHIROPRACTIC ASSOCIATES, P.A.

DR. ANDREW RIDDLE

*Gentle, effective care for all ages.*

DR. KELLY KEENER

### New Patient Intake

Title: Dr. Mr. Mrs. Ms. Miss (check one) Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: Single Married Other \_\_\_\_\_ Sex: Male Female

#### Spouse Data

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is your spouse a patient in the clinic? Yes No

#### Patient Employer Data

Employment Status: Employed (FT/PT) Student (FT/PT) Retired Homemaker Unemployed

Employer Name: \_\_\_\_\_

Address Line: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Job Title / Position: \_\_\_\_\_ Description: \_\_\_\_\_

#### Emergency Contact

Contact Name: \_\_\_\_\_ Contact Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**General Information:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Handedness:  L  R  A  
Smoke:  None  Pk/Day Years \_\_\_\_\_  
Alcohol:  None  Social  Moderate  Heavy  
Have you ever been disability rated?  Yes  No  
For What? \_\_\_\_\_

**Current Complaint:**

When did this episode begin/increase? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you believe is causing your symptoms?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the nature of your symptoms. (Deep, Aching, Stiff, etc): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Can you go to sleep without problems?  Yes  No  
Do you awaken because of pain?  Yes  No  
If yes, where is the pain that wakes you up? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you have sleep problems before?  Yes  No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Any prior history of current complaints?**

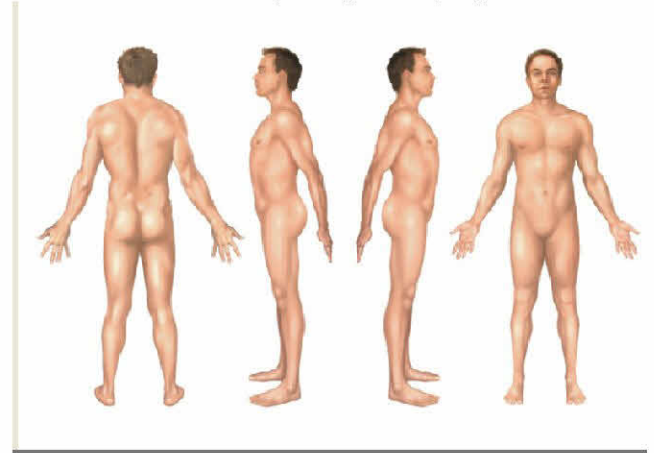
1: \_\_\_\_\_  
2: \_\_\_\_\_  
3: \_\_\_\_\_

**Prior treatment by a chiropractor for these?**

1: \_\_\_\_\_  
2: \_\_\_\_\_  
3: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Patient #: \_\_\_\_\_

**Please mark where your pain/symptoms are:**



**Please grade your pain on a scale of 0-10:**  
[0= No Pain, 10= Extreme Pain]

**Choose how frequent the pain is present:**

- Neck: 0 1 2 3 4 5 6 7 8 9 10  
 Constant -  Frequent -  Intermittent -  Seldom
- Upper Back: 0 1 2 3 4 5 6 7 8 9 10  
 Constant -  Frequent -  Intermittent -  Seldom
- Lower Back: 0 1 2 3 4 5 6 7 8 9 10  
 Constant -  Frequent -  Intermittent -  Seldom
- Other: \_\_\_\_\_  
 0 1 2 3 4 5 6 7 8 9 10  
 Constant -  Frequent -  Intermittent -  Seldom

**Please describe what activities aggravate your symptoms:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please describe what activities relieve your symptoms:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment History:**

Any prior Doctor seen for this condition?

Yes  No

**1. Doctor Name:** \_\_\_\_\_

Specialty: \_\_\_\_\_

Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Treatment type: \_\_\_\_\_

Treatment frequency and duration: \_\_\_\_\_

Currently treating?  Yes  No

If yes, describe: \_\_\_\_\_

Tests performed: \_\_\_\_\_

Referred to: \_\_\_\_\_

Did treatment help you?  Yes  No

Notes: \_\_\_\_\_

\_\_\_\_\_

**2. Doctor Name:** \_\_\_\_\_

Specialty: \_\_\_\_\_

Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_

Treatment type: \_\_\_\_\_

Treatment frequency and duration: \_\_\_\_\_

Currently treating?  Yes  No

If yes, describe: \_\_\_\_\_

Tests performed: \_\_\_\_\_

Referred to: \_\_\_\_\_

Did treatment help you?  Yes  No

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medical History:**

Current Health Problems:  None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medications Taken:

Vitamins/Supplements  None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History:**

Surgeries (Dates & Type) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Fractures (Dates & Type) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Serious Illness/Conditions (Dates & Type) : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sports or Other Injuries to Head, Neck, or Back:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ 3

**Patient #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorization, Consent and Release**

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependant during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian of Minor Patient

\_\_\_\_\_  
Date

**Financial Policy**

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, we accept Visa and MasterCard.

**Your Insurance**

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered.** We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

**Missed Appointments**

In order to provide the best possible service and availability to all our patients, there may be a \$15.00 fee for any doctor appointment not canceled at least 24 hours in advance. Also, due to the scheduling of massage therapy, there may be a fee of 75% of our regular massage charges for appointments not canceled at least 24 hours in advance. Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

**Acknowledgment of Privacy Practices**

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependant to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian of Minor Patient

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_

Patient #: \_\_\_\_\_ Date: \_\_\_\_\_

MILFORD  
375 MULLETT RUN ST.  
MILFORD, DE 19963



GEORGETOWN  
20728 DUPONT BLVD., SUITE 317  
GEORGETOWN, DE 19947

ATLANTIC CHIROPRACTIC ASSOCIATES, P.A.

DR. ANDREW RIDDLE

*Gentle, effective care for all ages.*

DR. KELLY KEENER

**RECORD RELEASE**

I, \_\_\_\_\_ / \_\_\_\_\_  
Patient Name Date of Birth

hereby request my records and/or imaging reports be released from:

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Organization

and to be faxed/mailed/taken to Atlantic Chiropractic Associates, P.A.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient #: \_\_\_\_\_ Date: \_\_\_\_\_