Mitchell Chiropractic
2098 Teron Trace, Suite 300
Dacula, GA 30019

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ M.I.___ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Current Address: _____ **City:** _____

State: _____ **Zip:** _____ **SS#:** _____ **Home #:** _____

Cell #: _____ **Employer:** _____ **Occupation:** _____

Work #: _____ **Marital Status:** _____ **Spouse's Name:** _____

Spouse Phone #: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Low Back, Hip, Neck pain/ muscle pain				

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications?	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Medication	Reaction

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

INSURANCE INFORMATION

Primary Insurance Company: _____

Insurance Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone #:** _____

Policy/ID #: _____ **Group #:** _____

Relationship of Insured to the patient (Circle one): Self / Spouse / Child / Other

Name of Insured: _____ **Insured date of birth:** _____

I understand that insurance is being filed as a courtesy for me. I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered and that any amount authorized to be paid directly to Mitchell Chiropractic will be credited to my account upon receipt. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Co-pays, co-insurance, deductibles, or any dates of service denied by my insurance company are ultimately my responsibility and due at the time of service. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered will be immediately due and payable. I certify this information is true and correct to the best of my knowledge; I will notify the office of any changes in my status of the above information.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____