Dr. John Thomas Cece
Chiropractic Physician

Chiropractic
Physical Medicine
Sports Medicine

Date: _____

Full Name: _____ **Date of Birth**: _____ **Age**: ____ ☐ **Male** ☐ **Female**
Home Address: _____ **City**: _____ **State**: ___ **Zip**: _____
Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____
**** Please indicate preferred phone #: ☐Home ☐Work ☐Cell*** **Social Security #**:_____

****I would like to receive Email /Text Appointment Reminders: ☐ Yes ☐ No***
Email Address: _____

Employer: _____ **Employer Address**: _____
City: _____ **State**: ____ **Zip**: _____

Spouse/Significant Other: _____ **Phone**: _____
Emergency Name & Number (if different from above): _____

Insurance Company Name: _____ Insurance Co. Phone Number: _____
Name of Policy Holder: _____ **Policy Holder Date of Birth**: _____
Member ID#: _____
****If you are seeing the doctor as a result of an auto accident, please provide:***
Insurance Company Name: _____ Policy #: _____ Phone #: _____
Claims Adjuster: _____ Claim #: _____

How did you hear about the doctor? Who can we thank for referring you to our office? _____

YOUR HEALTH PROFILE

What is your primary reason for seeking chiropractic care at this time? _____
_____
Have you ever had the same issue(s) before? ☐ No ☐ Yes (explain) _____
What other providers have you seen for these complaints? _____
_____
When/how did your symptoms begin? _____
_____
Are there any major injuries/surgeries we should know about? _____
_____
My current symptoms interfere with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure
What is the most important aspect of life that your current pain prevents you from doing/enjoying?
_____
_____
Have you ever seen a chiropractor before? _____
What are your overall health and wellness goals? _____
_____
Do you play any sports? _____
How would you describe your overall health? _____
In my daily activities/work I *(check one):* ☐ Sit more than stand ☐ Stand more than sit ☐ Sit/Stand equally ☐ Walk frequently

71 Franklin Turnpike, Suite 5, 2nd Floor
Waldwick, NJ 07463
Phone: 201-445-9739 Fax: 201-445-9401

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Financial Responsibility and Consent

Please be advised that all treatment recommendations made in this office are individualized and constructed in the best interest of your health and wellness. Kindly read and sign the following:

Patient Name (print): _____ Date of Birth: _____ Email: _____
Address:_____ (Cell) _____ (Home) _____

- **Assignment of Insurance Benefits:** I authorize and direct that payment be made directly to: **Dr. John T. Cece, 71 Franklin Turnpike, Suite #5, Waldwick, New Jersey 07463,** for any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

  Date: _____ Patient Signature: _____

- **Release of Information**: I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

  Date: _____ Patient Signature: _____

- **Payment Agreement**: I understand that my medical insurance is a contract between me and my insurance carrier, and that the benefits quoted by my insurance carrier are not a guarantee of payment and are subject to review based on the terns of my individual contract. Notwithstanding claim denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges for treatment in this office.

  Date: _____ Patient Signature: _____

HIPAA Notice of Privacy Practices Statement

How We Collect Information About You: Cece Chiropractic (CC) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that are considered patient confidential, restricted by law, or specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between IHSN and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, or insurance. If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of CC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

RECEIPT OF HIPAA PRIVACY NOTICE

My signature, below, certifies I have reviewed the above NOTICE OF PRIVACY PRACTICES and may receive a copy upon request.

***Signature of patient (or Guardian if under 18)**: _____ **Date**: _____
*Comments, if any: _____

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Electronic Health Records Intake Form
(In compliance with requirements for the new government health care standards.)

First Name: _____ Last Name: _____ DOB: ___/___/___

Gender (circle one): Male / Female / Other **Preferred Language**: _____ **Home Phone Number**: _____

Email Address: _____ Cell phone Number: _____

Preferred method of communication for patient reminders (circle one): Email / Text Reminder

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

CMS (Center for Medicare Services) requires providers to report both race and ethnicity

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

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

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg, once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Height: _____ Weight: _____

□ **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.)

Patient (or guardian, if under 18) Signature: _____ Date: _____

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HEALTH CONCERNS/HISTORY (*Please check all that apply*)

☐ Anxiety/Depression	☐ Fatigue/Sleep Issues	☐ Hypertension	☐ Diarrhea/Constipation	☐ Dizziness/Fainting	☐ Nausea/Vomiting	☐ Ringing In Ears
☐ Sensitivity to Light	☐ Loss of Concentration	☐ Diabetes	☐ Memory Problems	☐ Loss of Balance	☐ Headaches	☐ Neck/Back Pain
☐ Stiffness/Flexibility	☐ Pain in Arms/Legs	☐ Sinus Troubles	☐ Cold Hands/Feet	☐ Allergies	☐ Irritability	☐ Mood Swings
☐ Loss of Taste	☐ Numbness: fingers/toes	☐ Menstrual Pain	☐ Pins & Needles in arm/legs	☐ Ulcers or Heartburn	☐ Menstrual Irritability	☐ Cancer/Tumor
☐ HIV/AIDS	☐ Recent Infection or Fever	☐ Osteoporosis	☐ Numbness in Groin/Buttocks	☐ Recent Trauma	☐ Abnormal Weight – gain or loss	
☐ Epilepsy/Seizures	☐ Frequent Urination	☐ Urinary Retention	☐ History of Low/Mid Back Pain	☐ History of Neck Pain	☐ Visual Disturbances	☐ Arthritis
☐ Aortic Aneurysm	☐ Hot Flashes or Cold Sweats	☐ Prostate Problems	☐ Pregnancy, # of births_____	☐ Wear orthotics	☐ Broken bones *(explain):* _____	

Other:_____

Explain any boxes checked above or add additional concerns: _____
_____

MEDICATIONS/VITAMINS/SUPPLEMENTS

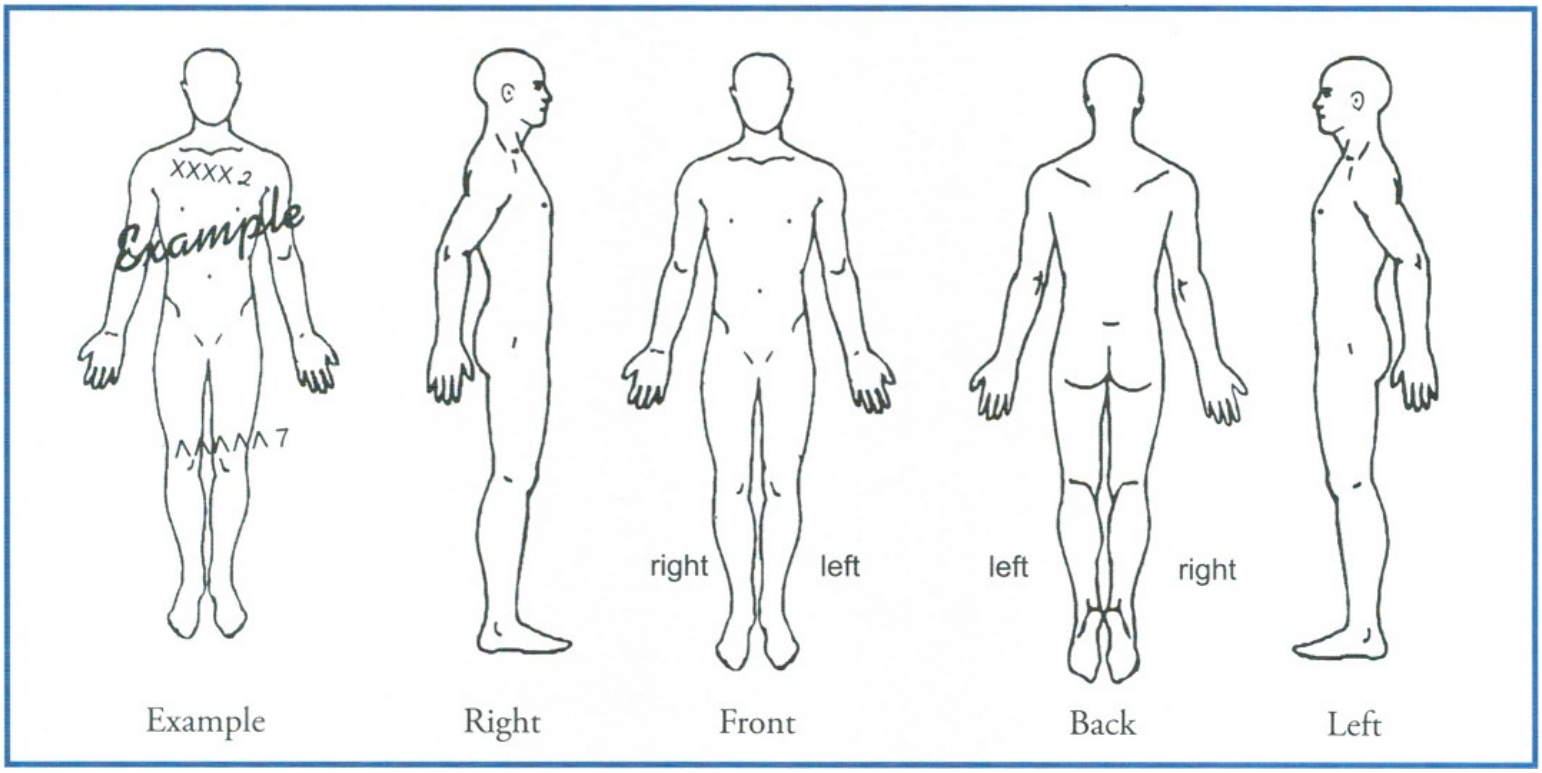
☐ Anxiety/Depression ☐ ADD/ADHD ☐ Cholesterol ☐ Diabetes ☐ Blood Pressure ☐ Pain Narcotics ☐ Migraine/Headache ☐ Corticosteroid Use (Steroid Inhaler)
☐ Muscle Relaxers ☐ Birth Control Pills ☐ Other: _____ Explain checked boxes: _____

☐ Multi-Vitamin ☐ Vitamin D3 ☐ Fish Oil/Omega-3 ☐ Probiotics ☐ Other: _____ ☐ Explain checked boxes: _____

Pain Drawing

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (mild discomfort) to 10 (extreme pain).

Numbness	Pins & Needles	Burning	Aching	Stabbing
---------	o o o o o o	^^^^^	xxxxx	• • • •



No Pain /_____/ Worst Possible Pain

Please make a slash through the above line as to the level of your pain

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