

**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, 2<sup>nd</sup> 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 terms 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: \_\_\_\_\_

- **Consent to share medical/financial Information:**

- I authorize the office of **Dr. John T. Cece** to share **Medical Information with:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

- I authorize the office of **Dr. John T. Cece** to share **Financial Information with:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

## Consent For Email/Text Communication

- May we phone, email or send you a text to confirm appointments?  Yes  No
- May we leave a message on your answering machine at home or on your cell phone?  Yes  No
- May we email you about your financial account upon your request (year-end statements, etc.)?  Yes  No
- May we email you clinical information upon your request (Xray reports, etc.)?  Yes  No

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

**\*Signature of guardian (if patient is under 18 years of age):** \_\_\_\_\_ **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 Name (print):** \_\_\_\_\_

**\*Signature of patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**\*Signature of guardian (if patient is under 18 years of age):** \_\_\_\_\_

**Date:** \_\_\_\_\_

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

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

Other: \_\_\_\_\_  
Explain any boxes checked above or add additional concerns: \_\_\_\_\_

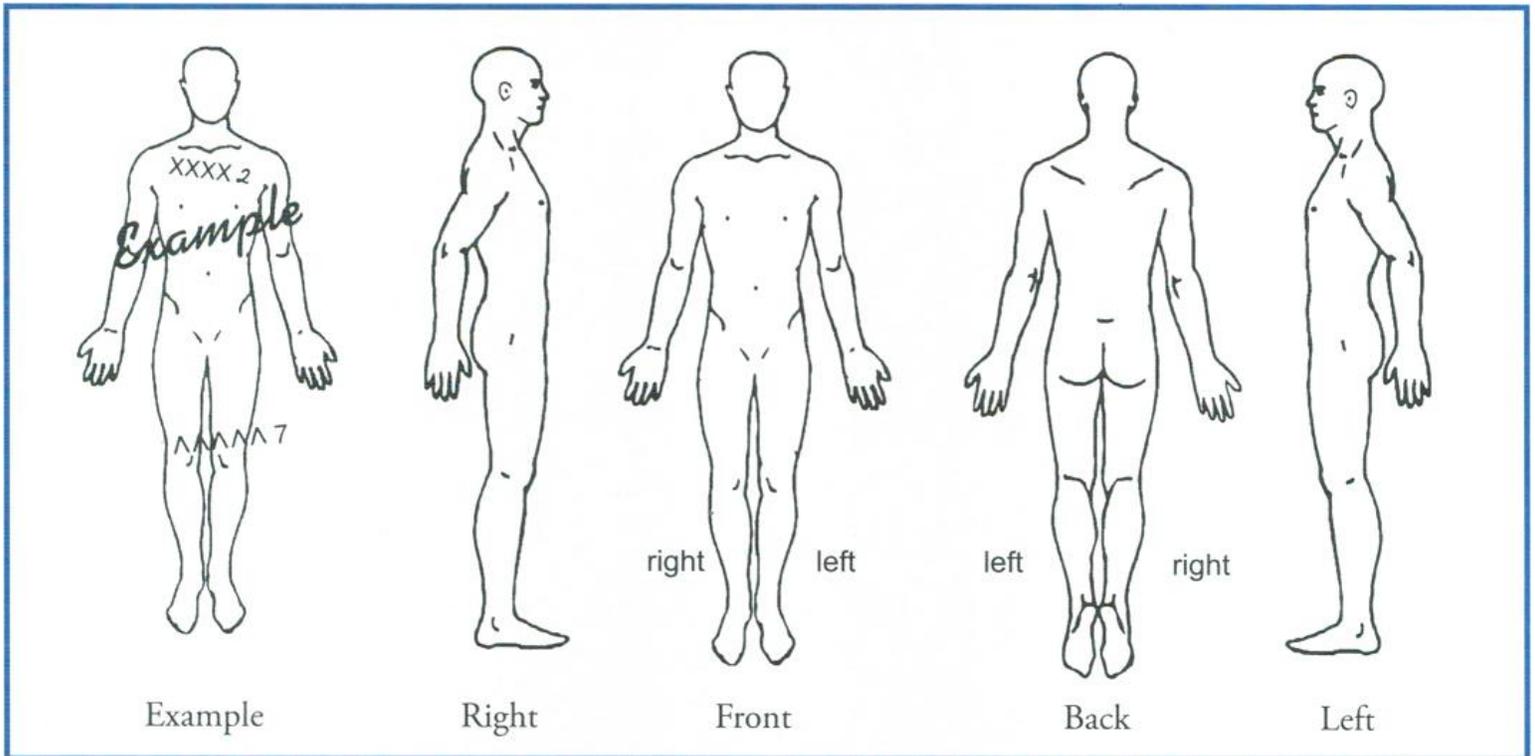
**MEDICATIONS/VITAMINS/SUPPLEMENTS**

- |   |  |   |                                     |   |   |  |   |
|---|--|---|-------------------------------------|---|---|--|---|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Cholesterol      | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Pain Narcotics | <input type="checkbox"/> Migraine/Headache | <input type="checkbox"/> Corticosteroid Use (Steroid Inhaler) |
| <input type="checkbox"/> Muscle Relaxers    | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Other: _____     | Explain checked boxes: _____        |   |   |  |   |
| <input type="checkbox"/> Multi-Vitamin      | <input type="checkbox"/> Vitamin D3          | <input type="checkbox"/> Fish Oil/Omega-3 | <input type="checkbox"/> Probiotics | <input type="checkbox"/> 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      ^ ^ ^ ^ ^      x x x x x      • • • • •



No Pain | \_\_\_\_\_ | Worst Possible Pain

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