South Miami Chiropractic

"It's Your Future! Be there Healthy!"

****

NEW PATIENT QUESTIONNAIRE

CONFIDENTIAL HEALTH INFORMATION & CONDITION FORM

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all Federal privacy standards. PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Today's Date: ____/____/____

Patient Name:_____

Social Security Number _____

Birth Date: ____/____/____ Age: ____ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____

Date of Birth: ___/___/___ Phone: (___) _____

Mother: _____

Date of Birth: ___/___/___ Phone: (___) _____

Guardian: _____

Date of Birth: ___/___/___ Phone: (__) _____

Who do you normally live with? ☐ Mother and Father

☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: □ Married □ Separated □ Widowed

□ Single How many children? _____

CURRENT ADDRESS

Street_____

_____

_____

City_____ State ____ Zip _____

Email: _____

Cell Phone (_____) _____

Home Phone (_____) _____

FOR ADMINISTRATIVE USE:

SOURCE: _____ ROF DATE: _____

SERVICES INCLUDED: □ NP Exam □ X-Rays

□ Adjustment □ Cold Laser □ Hot Laser

□ Decompression C - L □ Massage

□ _____ □ _____

INSURANCE CARD: □ Yes □ No □ Denied

INSURANCE VERIFICATION:

IN NETWORK - OUT OF NET

Deductible:

Co-Pay:

Co-Ins:

How do you preferred to receive our communications:

□ Text □ Email □ Voice Call

Your Occupation _____

Employer _____

Work Phone (_____) _____

Student at _____

□ FULL-TIME □ PART-TIME

Name of Spouse_____

Spouse's Date of Birth ____/____/____

Spouse's Occupation_____

Spouse's Employer _____

Work Phone (_____) _____

Spouse is a student at _____

□ FULL-TIME □ PART-TIME

Who should we contact in the event of an emergency?

_____

Phone (_____) _____

Address of emergency contact person

_____

_____

South Miami Chiropractic

"It's Your Future! Be there Healthy!"

****

How did you learn about us?

☐Groupon ☐ Yelp ☐ Google

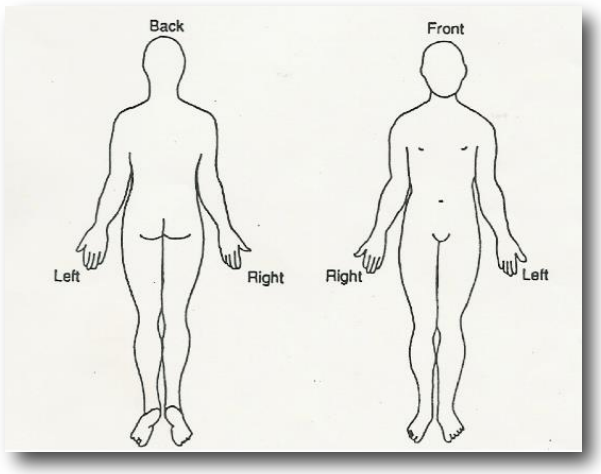
☐ Current Patient (Name) _____

☐ Insurance Book ☐ Walk In ☐ Other _____

Describe your condition, symptoms, or the purpose of this appointment:

_____
_____
_____
_____
_____

PLEASE MARK THE AREAS OF PAIN OR DISCOMFORT
Please check ALL that apply



Have you ever had the same or similar condition?
□ YES □ NO If yes, when and describe:

_____
_____

Is your condition or injury due to:

An Automobile accident?
□ YES □ NO
If YES, briefly describe:

_____
_____
_____

A work-related accident or cause?

□ YES □ NO

If YES, briefly describe:

_____
_____
_____

If the condition did not result from an automobile accident or relates to your work, *how and where did the symptoms start?*

_____
_____
_____

Approximately, when did your injury or condition occur?

ONSET DATE: ____/____/_____

In a scale from 0 to 10 where 0 means ABSENT and 10 AGONIZING PAIN:

how extreme are your current symptoms:

0 1 2 3 4 5 6 7 8 9 10

How does this condition currently interfere with your life and ability to function?

	No effect	Mild	Moderate	Severe
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending Over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a Computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for Family	☐	☐	☐	☐

CONTINUES IN NEXT PAGE

South Miami Chiropractic

"It's Your Future! Be there Healthy!"

****

Please indicate any **other healthcare providers** who you have seen **FOR THIS INJURY OR CONDITION**, and when you last saw them.

1) Name: _____

Type of Practice: _____

Date of Last Visit: ____/____/_____

2) Name: _____

Type of Practice: _____

Date of Last Visit: ____/____/_____

Date of last physical examination? ____/____/_____

What **surgeries** have you had and

when?_____ Date: ____/____/___

_____ Date: ____/____/____

_____ Date: ____/____/___

_____ Date: ____/____/_____

Do you suffer or have you suffered from any **Serious illnesses or conditions**?

_____ □ Had □ Have

_____ □ Had □ Have

_____ □ Had □ Have

_____ □ Had □ Have

Have you ever **suffered** from:

□ Dizziness □ Arthritis □ Digestive Disorders

□ Backaches □ Headaches □ Nervousness

□ Heart Trouble □ Numbness □ Sinus Trouble

□ Diabetes □ Asthma □ Anemia

□ Hernia □ Neuritis □ Cancer

Have you been **treated for any health condition** by a *physician or health* ***practitioner*** **in the last year**?

□ YES □ NO

Describe:_____

_____

_____

_____

WOMEN ONLY:

Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

What **medications or drugs** are you taking?

_____

_____

_____

_____

Some Health Issues are Hereditary. Please tell us about the health of your immediate family members:

Relative	Age (if living)	Health	Illnesses
Mother	_____	Good Poor	_____
Father	_____	Good Poor	_____
Sister 1	_____	Good Poor	_____
Sister 2	_____	Good Poor	_____
Brother 1	_____	Good Poor	_____
Brother 2	_____	Good Poor	_____

Tell us about your health habits and stress levels:

Alcohol Use □ Daily □ Weekly How much? _____

Coffee Use □ Daily □ Weekly How much? _____

Tobacco Use □ Daily □ Weekly How much? _____

Exercising □ Daily □ Weekly How much? _____

Pain Relievers □ Daily □ Weekly How much? _____

Soft Drinks □ Daily □ Weekly How much? _____

Water Intake □ Daily □ Weekly How much? _____

Hobbies _____

Prayer or meditation? □ Yes □ No

Job pressure/stress? □ Yes □ No

Financial peace? □ Yes □ No

****

South Miami Chiropractic

"It's Your Future! Be there Healthy!"

****

Vaccinated? □ Yes □ No

Mercury fillings? □ Yes □ No

Recreational Drugs? □ Yes □ No

HEALTH INSURANCE INFORMATION:

Do you have health insurance? □ YES □ NO □ Not Sure

Company: _____

Full Name of Policy Holder:

_____

Policy Holder's Date of Birth ____/____/_____

Relation to Policy Holder: □ Self □ Spouse □ Parent

Does the policy holder have the insurance through his/her employer? □ YES □ NO

If yes, who is the employer?

_____

ABOUT YOUR HEALTH INSURANCE -PLEASE READ AND INITIAL

_____ I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office.

ASSIGNMENT OF BENEFITS

I _____ hereby authorize Chiromedic Family Practice to bill my insurance carrier for all medical services rendered. I also authorize my insurance carrier to direct all medical payments directly to:

Chiromedic Family Practice, LLC
6075 SW 72nd Street, Suite 203
Miami, FL 33143
NPI # 1295152742 Tax Id# 46-5157434

_____ **I also understand that should my insurance carrier send any medical payments to me directly, that I will forward all checks and explanation of benefits to Chiromedic Family Practice, LLC.**

____ I **agree to pay my estimated patient responsibility** and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims.

____ In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing.

____ I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

_____ **I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney's** who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

ABOUT YOUR CARE PLEASE READ AND INITIAL

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and INITIAL your agreement.

_____ **I instruct the Chiropractor to deliver the care, that, in his or her professional judgement, can best help me in the restoration of my health.** I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the **Privacy Policy** and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period: ___/____/____**

_____ I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office

_____ I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient or Legal Guardian's Signature:

_____

Print Name:_____

If a patient is a minor child, print Child's Full Name:

_____

Date: ____/____/____

****