PATIENT INTRODUCTION

Please answer the following questions completely

Name: ____________________________ SS #: ____________________

Address: ____________________________ Apt#: _____ City: ___________ St: ___ Zip: ______

Home Phone#: (____) ________________ Work Phone #: (___) ______________

Employer: ________________________ Occupation: ____________________________

Duties/ Daily Activities @ Work: ____

Sex: M F Marital Status: S M D W Age: ________ Date of Birth: ___ / ___ / ______

How did you hear about our clinic? ____

Describe Problem: ____

Have You had Chiropractic Care before? _____ Yes _______ No If so, Who was the chiropractor? ________________

When was your last visit? ___________ Where? ______________ How were the results? ______________________________

Is it possible you are Pregnant? _____ Yes _____ No Do you have health insurance? _____ Yes _____ No

Are you here because of : _______ An Auto Accident Date injured: ____ / ____ / ________

_______ An on the job injury Do you have an attorney? _______ Yes _______ No

Date of last physical exam: _____ / ____ / __________ Reason: ______________________________

Please list all accidents, falls, injuries, surgeries, major illnesses, or traumas no matter how long ago they occurred.

TYPE	DATE	DESCRIBE/COMMENTS

ARE YOU PRESENTLY TAKING ANY MEDICATIONS?

NAME OF DRUG	AMOUNT	DESCRIBE/COMMENTS

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

___Headaches
___Shooting head pains
___Sinus Pain
___Loss of smell
___Hay fever
___Loss of taste
___Tightness in throat
___Inflammation in throat
___Thyroid Trouble
___Face flushed
___Twitching of face
___Loss of memory
___Irregular sleep
___Leg/Feet pain
___Neck pain

___Head feels heavy
___Dizziness
___Fainting
___Loss of balance
___Stress
___Muscle spasm in neck
___Grating in neck
___Tight shoulder muscles
___Neuritis-arms/shoulders
___Pins and Needles
___Arms/hands pain
___Cold hands
___Fatigue
___Depression
___Ringing in ear(s)

___Heart Pain
___Heart Palpitation
___Mid-Back Pain
___Heart Attacks
___High Blood Pressure
___Anemia
___Nervous Stomach
___Stomach trouble
___Ulcers
___Nerves & nervousness
___Irritability
___Cold sweats
___Chest pains
___Shortness of breath
___Cold/Heat intolerability

___Indigestion
___Intestinal Gas
___Low back pain
___Constipation
___Menstrual Cramps
___Menstrual Irregularity
___Diabetes
___Swelling
___Arthritis
___Ruptured Disc
___Pinched Nerve
___Night sweats
___Liver trouble
___Gallbladder trouble
___Allergies

___Other: (please explain:) ____

Are any of your family members experiencing any of the above difficulties?

Family members: ________________________ Difficulties: ______________________________

________________________ ______________________________

____

Do you have any family history of diseases? If so, please explain: ______________________________

____

Amount of sleep you get per night (hours): ___________ Position you sleep in at night: __________________

Is your sleep: Great Good Fair Poor

PRESENTLY: Quality of Life Value (1-100): ____________________

Performance Level of Daily Functions (1-100): ______________

PAYMENT/INSURANCE INFORMATION

Please complete all applicable information

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
S A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU

( ) **CASH/CHECK:** Payment is due in full when services are rendered.

( ) **INSURANCE:** We will file your medical insurance for you. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.

( ) **AUTOMOBILE INSURANCE:** We must have verification of insurance, a copy of your insurance card, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.

( ) **WORKER'S COMPENSATION:** Authorization for treatment must be in writing from your employer. If this is not possible on the first visit, we will accept verbal authorization until authorization can be obtained in writing.

( ) **MEDICARE:** We must have a copy of your Medicare card or verification of coverage.

Insurance Information:

Insured's Full Name: ______________________ Insured's Date of Birth:__/__/___
Relationship to the Insured: __________________ Home Phone: (__)________
Insured's SS #: ____________________________
Insurance Company Name: ____
Insurance Company Phone Number: (__)__________ Group #: ___________
Insured's Employer: ______________________________ Phone #: (__)_______

I ________________________________, have read the above and checked one method of payment. I have agreed that the balance is my responsibility and will pay any balance that has gone unpaid over 60 days. If balance owed after stated period has not been met, I understand that I will be responsible for ALL fees incurred(attorney fees, collection agency fees, court costs, interest and any other fees needed to collect the balance) such that the balance owed to this office is paid in full.

Patient Signature:____________________ Witness: ___________________
Date: _______________

FLORIDA CHIROPRACTIC CLINICS

PATIENT AND DOCTOR AGREEMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that we will be using to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than to correct vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method to achieve this is specific chiropractic adjustments to correct vertebral subluxations.

I, ____________________ have read and fully understand the above statements.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy, or had the opportunity to read, the NOTICE OF PRIVACY PRACTICES (located in the waiting room) and that I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES. I understand that this form will be placed in my patient chart and maintained for six years.

____________________________________ ______________
Patient Name (please print) Date

____
Parent, Guardian or Patient’s legal representative

____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT’S CHART AND MAINTAINED FOR SIX YEARS.

FLORIDA CHIROPRACTIC CLINICS, INC.

OFFICE POLICIES AND GUIDELINES PERTAINING TO APPOINTMENTS

MISSED APPOINTMENTS and FINANCIAL AGREEMENTS

Our facility attempts to accommodate our patients by giving appointments that meet their schedules. We understand that things pop up prior to or at the last minute. As a courtesy we appreciate a phone call letting us know that you will be late or not be able to attend and thus, we can modify our schedule accordingly. Numerous times, other patients wish to obtain an office visit at the same time as what you wish to as well. We only have a certain number of time slots available to accompany our patients. If you can not make your scheduled appointment and you call in, we can fill your time slot with another patient who wishes to come in. Our office feels this is a common courtesy to us, you and other patients. However, others may not feel that way as we still encounter situations where patients do not notify us of not being able to meet their appointment. As a result, our office has a $30 fee for any patient that fails to notify the office of a cancellation, regardless if you are a cash, insurance, or automobile accident patient.

You have two options. Please provide your initials by your choice below.

____ Option A, I am providing a undated check made out to Florida Chiropractic in the amount of $30.00. This check is to be on file to cover any missed appointment that I fail to call and cancel. If I do not violate this policy, the **CHECK WILL NEVER BE CASHED.**

____ Option B, I am providing to Florida Chiropractic Clinics, Dr. Greg Yingling, my credit card information. The amount of $30.00 will ***ONLY BE CHARGED*** TO MY CREDIT CARD ***IF I FAIL*** to call and cancel a scheduled appointment. ***Shall I not violate this policy, UNDER NO*** circumstances will *MY CARD BE BILLED* or my information shared.

Card Holders Name (as on front of card) ______________________________

Type of Card: *Visa* *MasterCard* *Card #* ______________________ Exp Date: ____/____

Three or four digit number on the back of the card on the signature line ____ ____ ____ ____

______________________________ ______________________

Patients Signature Date

Cc: patient