Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Island Chiropractic's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

I grant Island Chiropractic the permission to use and disclose my Protect Health Information to the following people:

____

____

____

Signed: ______________________________ Date: ________________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: __________________________ Witnesses by: ____________________

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): ____________________________________

By: (name and title): ____

HEALTH INFORMATION (CONTINUED)

Have you ever suffered from:	Past	Present		Past	Present
High blood pressure	[ ]	[ ]	Kidney Stones	[ ]	[ ]
Heart problems	[ ]	[ ]	Stroke	[ ]	[ ]
Diabetes	[ ]	[ ]	Asthma	[ ]	[ ]
Dizziness	[ ]	[ ]	Cancer	[ ]	[ ]
Convulsions	[ ]	[ ]	Prostate problems	[ ]	[ ]
Loss of bladder control	[ ]	[ ]	Blood disorder	[ ]	[ ]
Abdominal pain	[ ]	[ ]	HIV/AIDS	[ ]	[ ]
Aortic Aneurysm	[ ]	[ ]	Other	[ ]	[ ]
Difficulty in swallowing	[ ]	[ ]			

Sleeping position: Back [ ] Side [ ] Stomach [ ] Pillows: How many ____
Cervical [ ] Orthopedic [ ]

Work Description __________________________ ____Full time/____ Part time

Age of Mattress ___________ Comfortable [ ] Uncomfortable [ ]

List surgical operations and year ____

Are you pregnant? Yes [ ] No [ ]

Present weight ___ lbs. Height ___ feet ___ inches Right handed [ ] Left handed [ ]

Medication list

Medication # 1
Date started __________________
Drug name____________________
Strength______________________
Dosage_______________________
Prescribed by _________________

Medication # 2
Date started __________________
Drug name____________________
Strength______________________
Dosage_______________________
Prescribed by _________________

Medication # 3
Date started __________________
Drug name____________________
Strength______________________
Dosage_______________________
Prescribed by _________________

Medication #4
Date started __________________
Drug name____________________
Strength______________________
Dosage_______________________
Prescribed by _________________

Allergies? ____

Smoking Status (Circle One)

Current Former Never

ISLAND CHIROPRACTIC P.C.

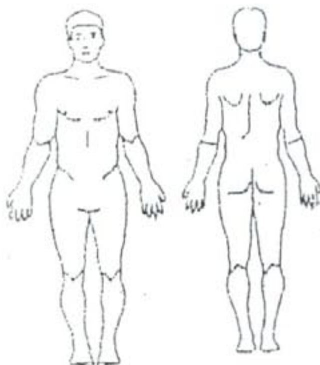
CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
THANK YOU.

Name________________________________ Age__________ Marital Status M S W D

HEALTH INFORMATION

Please mark your areas of pain on the figures below:



Have you had previous chiropractic care? [ ] Yes [ ] No

What is your major complaint? ______________________________

When did your problem begin? ______________________________

____

Describe how your problem began______________________________

____

What makes your symptoms worse? ______________________________

What makes your symptoms better? ______________________________

Have you been in an accident? [ ] Auto [ ] Work [ ] Other

If yes, when__________________ Describe ______________________________

Other doctors who recently treated this condition: ______________________________

Have you had this or similar conditions in the past? [ ] Yes [ ] No [ ] Similar

Are you symptoms [ ] Always present [ ] Frequent [ ] Occasional [ ] On and off

How bad is your pain or ache? (0-no pain, 10- a lot of pain) 0 1 2 3 4 5 6 7 8 9 10

Describe your pain [ ] Sharp [ ] Shooting [ ] Dull/ ache [ ] Stiff [ ] Tingling

[ ] Numbness [ ] Burning [ ] Throbbing [ ] Knife-like [ ] Other __________________

- CONTINUED ON OTHER SIDE -

Island Chiropractic, P.C.

PATIENT REGISTRATION

Patient Name:____________________ Sex: M / F Birthday:__________

Address:______________________ Social Security: ______________

______________________ Zip:__________ Marital Status: M S W D

Home Phone:____:____:____ Work:____:____:____ Cell:____:____:____

Email:______________________ Referred by Name:______________

PRIMARY INSURANCE COMPANY

Insurance Company:__________________ Insurance Company Policy #: ________

______________________Policy Holder:______________________

Birth date:________________Address:______________________

Social Security:____:____:____ Policy Holders Employer: ______________

Relationship to Patient: ______________Employers Address: __________

____

SECONDARY INSURANCE COMPANY

Insurance Company:______________________ Insurance Company Policy #: ____

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Financial Responsibility: I understand that health and accident policies are an arrangement between an insurance carrier and myself. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payments. In the event of non-payment, I am legally responsible for any collection fees involved in satisfying my debt.

Agreement of Insurance Benefits: I authorize payment of medical benefits for services rendered directly to Island Chiropractic, P.C., 131 Old Country Road, Hicksville, NY 11801 (516)822-1900. I also authorize this office to submit claims for benefits and services rendered without obtaining my signature for each claim submitted.

Patient signature:______________________________ Date:____________

Guardian or Spouse's Signature:______________________ Date:____________