PATIENT INFORMATION

Date ______________________________

Patient ____

Email Address ____

Address ____

____

Sex: q M q F Age _________ Birthdate ______________

q Single q Married q Widowed q Separated q Divorced

Social Security # ______________-_____________-_________________

Occupation ____

Employer ____

Employer Phone ____

Spouse's Name ____

Whom may we thank for referring you?

q Spouse/Family Member ________________________________

q Friend ____

q Doctor ____

q Attorney ____

q Other ____

PHONE NUMBERS

Home ____

Cell ____

Work ____ Ext. ______

Best time and place to reach you __________________________________

IN CASE OF EMERGENCY, CONTACT:

Name _____________________________ Relationship _______________

Contact Phone __________________________________ Ext. ______

INSURANCE

Who is responsible for this account? _______________________________

Relationship to Patient ____

Primary Insurance Co. ____

Subscriber's Name ____

Subscriber Birthdate, if not pt. _____________ SS#__________________

Relationship to Patient ____

Group/ID # ____

Is patient covered by additional insurance? q Yes q No

Insurance Co. ____

Group/ID # ____

Subscriber's Name ____

Subscriber Birthdate, if not pt. ______________SS#___________________

Relationship to Patient ____

ASSIGNMENT AND RELEASE/ AUTHORIZED SIGNATURE

I, the undersigned certify that I (or my dependent) have insurance coverage with __________________________and assign directly to Moss Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not the insurance agrees to pay or if they deny the claims. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who signs below. I authorize the use of this signature on all insurance submissions.

X____

Responsible Party Signature

____________________________________ __________________

ACCIDENT INFORMATION

Is condition due to an accident? q Yes q No Date _____________

Type of accident: q Auto q Work q Home q Other

To whom have you made a report of your accident?

q Auto Insurance q Employer q Worker Comp. q Other

Are you currently out of work due to the accident?

q Yes q No

Dates out of work _______________—_______________

Do you have any Attorney representing your case?

q Yes q No

Attorney Name:_______________________________

Please be sure to give the receptionist a copy of your Insurance Card(s) and Drivers license.

CURRENT SYMPTOM LIST

Name:____ Date: ____________________

Activities of Daily Living: <u>Check all the activities that you are unable to do or have difficulty with because of this problem.</u>

q Sitting q Standing q Lifting
q Moving Arms q Moving legs
q Bending at waist q Carrying
q Lying/sleeping q Pulling
q Pushing q Kneeling q Twisting or turning back q Twisting or turning neck q Turning over
q Reaching q Grooming q Dressing
qBathing q Going to the bathroom
q Recreational activities
q Golfing q Sexual relations
q Going up/down stairs
q Household chores/Housework
q Cough/sneeze q Riding in car

HEAD:
______Headaches
_____a. migraine in nature
_____b. back of Head
_____c. sinus (allergy)
_____d. temples
_____e. entire head
Frequency _____ x's per _________
_____ Head feels heavy
_____ Lightheadedness
_____ Fainting
_____ Eye Strain
_____ Light bothers eyes
_____ Blurred vision
_____ Double vision
_____ Dizziness
_____ Pain in the ears
_____ Ringing/buzzing in the ear/s
_____ Sinus trouble
_____ Jaw pain

CHEST:
_____Chest pain
_____Shortness of breath
_____Pain around the ribs
_____Irregular heartbeat

NECK:
_____ Neck pain and stiffness
_____ Neck pain
_____ Neck stiffness
_____ Neck pain with movement
____ forward
____ backward
____ turning to the left
____ turning to the right
____ bending to the left
____ bending to the right
_____ Muscle spasms in neck
_____ Grinding sounds in the neck
_____ Arthritis in the neck

SHOULDERS:
_____ Pain in the joint q L q R
_____ Pain across the shoulders
_____ Pain between shoulder blades
_____ Stiffness in shoulder qL q R
_____ Tension in the shoulders
_____ Muscle spasms q L q R
_____ Unable to raise arm over head/over shoulder level

ARMS & HANDS:
_____ Pain in the upper arm q L q R
_____ Pain in the elbow q L q R
_____ Tennis elbow q L q R
_____ Pain in forearm q L q R
_____ Pain in hands q L q R
_____ Pain in fingers q L q R
_____Sensation of pins and needles in Arms q L q R
_____Sensation of pins and needles in fingers q L q R
_____Numbness in arms q L q R
_____Numbness in hands q L q R
_____Fingers go to sleep q L q R
_____Stiffness in fingers q L q R
_____Hands get cold q L q R
_____Swollen joints in fingers
_____Loss of grip strength q L q R

MID-BACK:
_____Mid-back pain and stiffness
_____Mid-back pain
_____Mid-back stiffness
_____Muscle spasms in mid-back
_____Pain in kidney area

LOW BACK:
_____Low back pain and stiffness
_____Low back pain
_____Low back stiffness
_____Muscle spasms in low back

HIPS, LEGS & FEET
_____Pain in the buttocks q L q R
_____Pain in the hip joint q L q R
_____Pain down both leg
_____Pain down one leg q L q R
_____Leg cramps q L q R
_____Knee pain q L q R
_____ inside q L q R
_____outside q L q R
_____Pins & needles in legs q L q R
_____Numbness in legs q L q R
_____Numbness in feet q L q R
_____Numbness in toes q L q R
_____Swollen ankles q L q R
_____Swollen feet q L q R
_____Feet feel cold

GENERAL
_____Anxiety
_____Nervousness
_____Depression
_____Fatigue
_____Generally feel run down
_____Loss of weight ______lbs
_____Gain weight ______lbs

ABDOMEN:
_____Nausea
_____Gas
_____Constipation
_____Diarrhea
_____Hemorrhoids

<u>Women Only</u>:
_____Menstrual cramping
_____Irregular periods

Men Only:
_____Urinary frequency
_____Difficulty in starting urination
_____Night urination
_____Prostate swelling/pain

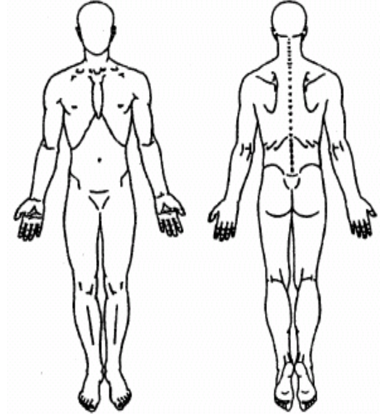
PATIENT CONDITION

Main Complaint:____

When did your symptoms appear? ____

Is this condition getting progressively worse? q Yes q No q Unknown

Mark an "X" on the picture where you continue to have pain, numbness, or tingling



NECK: q Sharp q Dull q Throbbing q Numbness q Aching
q Shooting q Burning q Tingling q Cramps q Stiffness q Swelling

Neck Pain is q Constant q Frequent q Intermittent q Occasional

Headaches are q Constant q Frequent q Intermittent q Occasional

On a scale from 1 – 10, where 1 feels great and 10 is the worst pain possible, please rate your pain: 1 2 3 4 5 6 7 8 9 10

MID BACK: q Sharp q Dull q Throbbing q Numbness q Aching
q Shooting q Burning q Tingling q Cramps q Stiffness q Swelling

Mid Back Pain is q Constant q Frequent q Intermittent q Occasional

On a scale from 1 – 10, where 1 feels great and 10 is the worst pain possible, rate your pain: 1 2 3 4 5 6 7 8 9 10

LOW BACK: q Sharp q Dull q Throbbing q Numbness q Aching
q Shooting q Burning q Tingling q Cramps q Stiffness q Swelling

Low back Pain is q Constant q Frequent q Intermittent q Occasional

On a scale from 1 – 10, where 1 feels great and 10 is the worst pain possible, please rate your pain:
1 2 3 4 5 6 7 8 9 10

OTHER AREA: ______________________________q Sharp q Dull q Throbbing q Numbness q Aching q Shooting q Burning q Tingling q Cramps q Stiffness q Swelling **Pain is** q Constant q Frequent q Intermittent q Occasional

Pain radiates into: q Shoulder/Arms q left q right q Hips/Legs q left q right Other:______________________________

CURRENT HEALTH HISTORY

What treatment **have you already received** for your current condition? (*circle all that pertain*) None
Medications Surgery Physical Therapy Chiropractic Adjustments Pain Management Injections
Other ______________________________

Name and phone numbers of other doctor (s) who have treated you for your condition:

____

____

Are you **presently** taking any medication –prescription or over-the-counter? Please list them here:

____

Has any other doctor/hospital taken any X-rays, MRI, CT Scans because of your present condition?
_____ Yes _____ No If Yes, When? ____________ (Date) Where? ______________________________

If, x-rays, were the x-rays taken while standing? _____ Yes _____ No

Have you had any laboratory work done lately? Blood Urine ______________________________

PREGNANCY DISCLAIMER:

Women: Is there any chance that you are pregnant? _____ Yes , I am ________months pregnant _____ No

PAST HEALTH HISTORY

Please mark any conditions that you currently have or conditions that you have had in the past:
Please check "P" for PAST and "C" for CURRENT.

P	C	Condition	P	C	Condition	P	C	Condition
q	q	AIDS/HIV	q	q	High Cholesterol	q	q	Rheumatoid Arthritis
q	q	HEPATITIS _______	q	q	Heartburn/Acid Reflux	q	q	Osteoarthritis
q	q	Asthma	q	q	Herniated Disc	q	q	Pneumonia
q	q	Osteoporosis	q	q	Prostate Problems	q	q	Heart Disease
q	q	Multiple Sclerosis	q	q	Epilepsy	q	q	Stroke
q	q	Diabetes	q	q	Hernia	q	q	Pacemaker
q	q	Heart Attack	q	q	Thyroid Condition	q	q	Other ________________________

Other Symptoms:

P	C	Symptom	P	C	Symptom	P	C	Symptom
q	q	Pain in Hands or Arms R L B	q	q	Chest Pains	q	q	Headaches q q Migraines
q	q	Neck Pain	q	q	Numbness in Hands or Arms R L B	q	q	Inability to concentrate
q	q	Sleeping Problems	q	q	Pain in Legs or Feet R L B	q	q	High Blood Pressure ____/____
q	q	Low Back Pain	q	q	Numbness in Legs or Feet R L B	q	q	Weight Loss/Gain
q	q	Pain Between Shoulders	q	q	Fatigue	q	q	Tension
q	q	Depression	q	q	Painful Urination	q	q	Irritability
q	q	Lights Bother Eyes	q	q	Thirsty	q	q	Dizziness
q	q	Loss of Memory	q	q	Frequent Urination	q	q	Nervousness
q	q	Shoulder Pain R L B	q	q	Constipation	q	q	Loss of Smell or Taste
q	q	Neck Stiffness	q	q	Diarrhea	q	q	Stomach Upset
q	q	Joint Swelling	q	q	Shortness of Breath	q	q	Menstrual Cramps
q	q	Fever	q	q	Sinus pain	q	q	Jaw pain/clicking R L B
q	q	Loss of Balance	q	q	Allergies	q	q	Flashes in eyes R L B
q	q	Nausea	q	q	Swelling	q	q	Loss of vision R L B

Please list any accidents or falls and the date of the incident: Car Accidents: ____

Falls: ______________________________ Sports: ______________________________ Other: ____________________________

List any broken bones (fractures) or dislocations: ____

Are you being treated for any other conditions that you have not told us about? ____

Date of last physical exam: ________________ Primary Care Physicians Name: ____

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
___________	Tonsillectomy	____________	Tubes in Ears	____________	Sinus
___________	Gall Bladder	____________	Kidney Stones	____________	Hernia
___________	Spinal Surgery	____________	Hysterectomy	____________	Cosmetic
___________	Other: __________________	____________	Other: __________________	____________	Appendectomy

q **I have never had any surgeries** **Notes:** ____

SOCIAL HISTORY/HABITS

			Exercise:	**Days per week:**	**Describe Exercise:**
Smoking	Packs/Day:	__________	_____ None		
Drinking	Alcohol/Week:	__________	_____ Mild	1 – 2	________________________
Caffeine	Cups/Day:	__________	_____ Moderate	3 – 4	________________________
Water	Glasses/Day:	__________	_____ Active	5 – 7	________________________

Sleep: **Hours per night** (circle one) 3 – 5 5 – 7 8 – 10 **Do you wake up tired?** _____ Yes _____ No

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Stroke	Other
Mother	q	q	q	q	q	q ________________________________
Father	q	q	q	q	q	q ________________________________
Brother, # of _____	q	q	q	q	q	q ________________________________
Sister, # of _____	q	q	q	q	q	q ________________________________
Children, # of _____	q	q	q	q	q	q ________________________________

OUR FINANCIAL POLICY / INSURANCE BENEFITS DISCLAIMER

Thank you for choosing Moss Chiropractic Clinic as your healthcare provider. We are committed to your treatment being a success. Our Insurance Department along with our Patient Care Managers will work very hard to make sure your paperwork is filed accurately and promptly.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. I understand that the service Moss Chiropractic Clinic provides for verification for insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Moss Chiropractic Clinic, the balance of my account will be billed to me and due to Moss Chiropractic Clinic. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. I understand that the doctors office will bill my secondary insurance one time as a courtesy. If they do not pay, I am responsible for paying the office within 10 days and it is my responsibility to get reimbursement from the secondary insurance company. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collec-

AUTHORIZATION AND ASSIGNMENT

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligate to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however that all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempt and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in this state of Florida.
5. I further agree that this Authorization is irrevocable until all monies owed Moss Chiropractic Clinic are paid in full.

X____

Patient signature or authorized person acting on patient's behalf

RECORDS RELEASE

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I specifically authorize disclosure of my protected health information to the following: ☐ **SPOUSE ONLY** ☐ **ANY IMMEDIATE FAMILY MEMBER**

☐ **OTHER** (please specify): ________________________________ Relationship:________________________

X____

Patient signature or authorized person acting on patient's behalf

I have read and understand the above Financial Policy. I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authorization for these procedure to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient**. I am the responsible party for payment of any treatment received or incurred on this account.** This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardians Signature: **X** ____ **Date:** ______________

Witness' Signature: **X** ____ **Date:** ______________

Medical Information Release

Would you like us to keep your primary care physician/family doctor apprised of your condition? This is good idea because with proper communication between each office, we can ensure that you are getting the highest quality of care possible.

Please provide your Primary MD's information below:

Name: ______________________________________

Clinic Name: ______________________________________

Address: ______________________________________

____

Phone: ______________________________________

Fax: ______________________________________

I, ________________________________, give permission to Dr. Moss, his staff, associates, and employees of Moss Chiropractic Clinic to share private and medical information with my medical doctor, ____________________________________, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Moss and his staff.

Signature: ________________________________ Date: ______________________

Patient Information

Name: ____

Address: ____

City, State, Zip: ____

Phone: _______________________________ Date of Birth: _________________

Moss Chiropractic Clinic 1377 Deltona Blvd. Spring Hill, FL 34606

Phone 352-683-7886 Fax 352-683-4799