PATIENT INFORMATION

Date _____

Patient _____

Email Address _____

Address _____

_____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Social Security # _____-_____-_____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Whom may we thank for referring you?

❑ Spouse/Family Member _____

❑ Friend _____

❑ Doctor _____

❑ 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? ❑ Yes ❑ 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 I 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

_____ _____
Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No Date _____

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

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Are you currently out of work due to the accident?

❑ Yes ❑ No

Dates out of work _____—_____

Do you have any Attorney representing your case?

❑ Yes ❑ No

Attorney Name:_____

Attorney Phone:_____

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: Check all the activities that you are unable to do or have difficulty with because of this problem.

❑ Sitting ❑ Standing ❑ Lifting ❑ Moving Arms ❑ Moving legs ❑ Bending at waist ❑ Carrying ❑ Lying/sleeping ❑ Pulling ❑ Pushing ❑ Kneeling ❑ Twisting or turning back ❑ Twisting or turning neck ❑ Turning over ❑ Reaching ❑ Grooming ❑ Dressing ❑ Bathing ❑ Going to the bathroom ❑ Recreational activities ❑ Golfing ❑ Sexual relations ❑ Going up/down stairs ❑ Household chores/Housework ❑ Cough/sneeze ❑ 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 ❑ L ❑ R
_____ Pain across the shoulders
_____ Pain between shoulder blades
_____ Stiffness in shoulder ❑L ❑ R
_____ Tension in the shoulders
_____ Muscle spasms ❑ L ❑ R
_____ Unable to raise arm over head/over shoulder level

ARMS & HANDS:

_____ Pain in the upper arm ❑ L ❑ R
_____ Pain in the elbow ❑ L ❑ R
_____ Tennis elbow ❑ L ❑ R
_____ Pain in forearm ❑ L ❑ R
_____ Pain in hands ❑ L ❑ R
_____ Pain in fingers ❑ L ❑ R
_____ Sensation of pins and needles in Arms ❑ L ❑ R
_____ Sensation of pins and needles in fingers ❑ L ❑ R
_____ Numbness in arms ❑ L ❑ R
_____ Numbness in hands ❑ L ❑ R
_____ Fingers go to sleep ❑ L ❑ R
_____ Stiffness in fingers ❑ L ❑ R
_____ Hands get cold ❑ L ❑ R
_____ Swollen joints in fingers
_____ Loss of grip strength ❑ L ❑ 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 ❑ L ❑ R
_____ Pain in the hip joint ❑ L ❑ R
_____ Pain down both leg
_____ Pain down one leg ❑ L ❑ R
_____ Leg cramps ❑ L ❑ R
_____ Knee pain ❑ L ❑ R
_____ inside ❑ L ❑ R
_____ outside ❑ L ❑ R
_____ Pins & needles in legs ❑ L ❑ R
_____ Numbness in legs ❑ L ❑ R
_____ Numbness in feet ❑ L ❑ R
_____ Numbness in toes ❑ L ❑ R
_____ Swollen ankles ❑ L ❑ R
_____ Swollen feet ❑ L ❑ 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

Women Only:

_____ Menstrual cramping
_____ Irregular periods

Men Only:

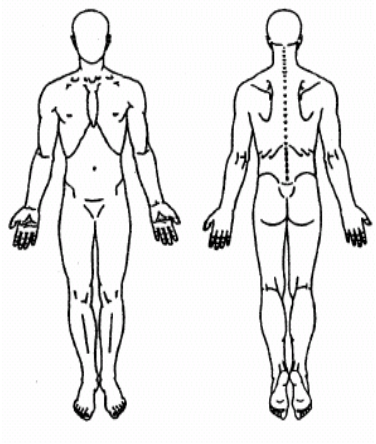
_____ Urinary frequency
_____ Difficulty in starting urination
_____ Night urination
_____ Prostate swelling/pain

PATIENT CONDITION

Main Complaint:_____

When did your symptoms appear? _____

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



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

NECK: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching
❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling
Neck Pain is ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional
Headaches are ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

MID BACK: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching
❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling
Mid Back Pain is ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

LOW BACK: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching
❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling
Low back Pain is ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

OTHER AREA: _____ ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling **Pain is** ❑ Constant ❑ Frequent ❑ Intermittent ❑ 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 Location: _____
1 2 3 4 5 6 7 8 9 10 Location: _____
1 2 3 4 5 6 7 8 9 10 Location: _____

Pain radiates into: ❑ Shoulder/Arms ❑ left ❑ right ❑ Hips/Legs ❑ left ❑ right Other:_____

CURRENT HEALTH HISTORY

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

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

_____

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

_____

Has any other doctor/hospital taken any X-rays, MRI, CT Scans because of your present condition?
_____ Yes _____ No
If Yes, When? _____ Date Where? _____
Were the x-rays taken while standing? _____ Yes _____ No
Have you had any laboratory work done lately? Blood Urine _____
Do you have any allergies? _____

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		P	C		P	C	
❑	❑	AIDS/HIV	❑	❑	High Cholesterol	❑	❑	Rheumatoid Arthritis
❑	❑	HEPATITIS _____	❑	❑	Heartburn/Acid Reflux	❑	❑	Osteoarthritis
❑	❑	Asthma	❑	❑	Herniated Disc	❑	❑	Pneumonia
❑	❑	Osteoporosis	❑	❑	Prostate Problems	❑	❑	Heart Disease
❑	❑	Multiple Sclerosis	❑	❑	Epilepsy	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Hernia	❑	❑	Pacemaker
❑	❑	Heart Attack	❑	❑	Thyroid Condition (high / low)	❑	❑	Cancer _____

Other Symptoms:

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

❑ **I have never had any surgeries** **Notes:** _____

SOCIAL HISTORY/HABITS

Smoking	Packs/Day:	_____	**Exercise:**	_____ None	**Days per week:**	**Describe Exercise:**
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	❑	❑	❑	❑	❑	❑ _____
Father	❑	❑	❑	❑	❑	❑ _____
Brother, # of _____	❑	❑	❑	❑	❑	❑ _____
Sister, # of _____	❑	❑	❑	❑	❑	❑ _____
Children, # of _____	❑	❑	❑	❑	❑	❑ _____

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 collection of the account.

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:** _____