

CAPE CORAL FAMILY CHIROPRACTIC, P.L.

210 DEL PRADO BLVD SOUTH, SUITE 3, CAPE CORAL, FL 33990

PATIENT INFORMATION

Date _____
SS# _____
Patient Name _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
City _____
State _____ Zip _____
Email _____
Sex ☐ Male ☐ Female Age _____
Birthdate _____
☐ Married ☐ Widowed ☐ Single
☐ Separated ☐ Divorced ☐ Minor
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer Phone (_____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____

PHONE NUMBERS

Home Phone (_____) _____
Cell Phone (_____) _____
Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT

Name _____
Relationship _____
Home Phone (_____) _____
Work Phone (_____) _____

INSURANCE

Subscriber's Name _____
Employer's Name _____
Relationship to Patient _____
Insurance Co. _____
Claim # _____
Group # _____
ID # _____
Adjuster's Name _____
Phone # _____
Attorney's Name _____
Phone # _____
Address _____

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent Guardian or Personal Representative

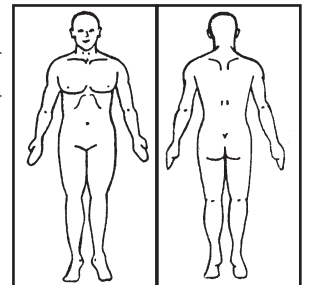
Date _____ Relationship to Patient _____
Drivers License # _____

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 ☐ Workers Comp. ☐ Other

PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____
Is this condition getting progressively worse? ☐ Yes ☐ No
Mark and X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Welling ☐ Other
How often do you have this pain? _____
Is it consistent or does it come and go? _____
Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Names and addresses of other doctor(s) who have treated you for your condition

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
MRI _____ CT Scan _____ Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Erectile Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleeplessness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical		Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

INJURIES/SURGERIES YOU HAVE HAD

DESCRIPTION

DATE

Falls	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Physician Name _____ Physician's Phone # _____ May we contact? ☐ Yes ☐ No

Patient Name: _____

FAMILY HISTORY	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Genetic Spinal Condition
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Neurological Problems
<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Polio
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Stroke/Heart Attack
Other _____	

OFFICE POLICY

I understand that fees are payable at time of services unless other arrangements are made in advance. I am responsible for my full co-payment and/or deductible on each visit. I understand that x-rays are the property of the clinic: however, I may borrow the films and receive reports. I understand that when I terminate care that all fees are immediately due and payable unless other arrangements are made in writing. I authorize this office to furnish requested information to my insurer or attorney with a properly signed release.

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself, furthermore I understand that this Chiropractic Office will prepare any necessary reports to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

ASSIGNMENT OF BENEFITS

I hereby authorize Cape Coral Family Chiropractic Center PL to release my information necessary to process this claim and ASSIGN ALL BENEFITS payable directly to Cape Coral Family Chiropractic. I waive the Statute of Limitations regarding my doctor's right to recover. I understand that whatever amount not collected from insurance proceeds I personally owe Cape Coral Family Chiropractic Center. If collection or legal actions should become necessary in payment of services rendered by Cape Coral Family Chiropractic Center I understand that I will be personally responsible for all fees incurred by said office.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he may designate as his assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic care or any clinic services that the doctor deems necessary in my case; and I further authorize him to disclose all or any part of my (patient) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patients employer.

Patient Signature: _____

Consent to treat and exam a minor: I authorize Cape Coral Family Chiropractic Clinic Physicians and whomever they designate as assistants to examine, x-ray and administer appropriate care as they deem necessary to my under age child.

Patient or Guardians signature: _____

CHIROPRACTIC TREATMENT WAIVER

NETWORK BLUE
MEDICARE ADVANTAGE
BLUE OPTIONS
BLUE SELECT
HEALTH OPTIONS
MIAMI-DADE BLUE
CIGNA

Under your plan, chiropractic care is now managed by a third-party administrator called American Specialty Health Network. Chiropractic benefits will be covered but with limitations. The initial exam along with 12 additional visits are covered without review. After the 12th visit American Specialty Health Network will request additional documentation from our office and you. Your x-rays must be submitted with a medical Necessity review form by us to the third party administrator.

American Specialty Health Network may determine your condition as not medically necessary or feel it is now considered "maintenance" care which is not covered by your policy. If this is their determination then they will not pay for your office visits past the 12th visit or your x-rays.

Since they seem to find the x-rays as always "not necessary" your care will be considered an elective wellness care with our office and therefore your x-rays will be your financial responsibility.

I understand that I have the option of having continued services performed in this chiropractic physician's office after the 12 visits but I will be responsible for any non-covered services.

I have read and understand my benefits.

Services to be performed: Examination, x-rays, adjustment and therapy

Patient Name: _____

Signature: _____ Date: _____