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 _____

Employer/School Address _____

_____

Employer Phone (____) _____

Spouse's Name _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Phone Carrier (Verizon, etc) _____

IN CASE OF EMERGENCY CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Cell 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

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have your 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 (lease pain) to 10 (severe pain) _____

Type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Welling ☐ Other

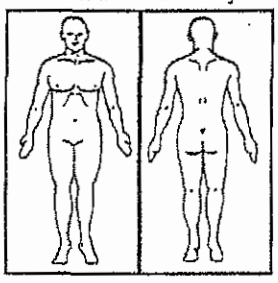
How often do you have this pain? _____

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

Mark areas on body



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

EXERCISE
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS
□Smoking Packs/Day _____
□ Alcohol Drinks/Week _____
□ Coffee/Caffeine Drinks Cups/Day _____
□ High Stress Level 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	
□ Arthritis	□ Asthma
□ Back Pain	□ Cancer
□ Depression	□ Diabetes
□ Epilepsy	□ Genetic Spinal Condition
□ High Blood Pressure	□ Heart Problems
□ Multiple Sclerosis	□ Neurological Problems
□ Parkinson's	□ Polio
□ Prostate Problems	□ 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 waiver 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 of to a family member or employer of the patent 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: _____