Informacion Basica de el paciente

Cash **Fecha: _____**

Apellido:	**Nombre:**			**Inicial:**
Direccion:		**Pueblo:**	**Estado:**	**Zip:**
Telefono de la casa o celular:	**Telefono del trabajo:**			**Numero de seguro social:**
Fecha de nacimiento:	**Fecha la lesion o comienzo de el dolor:**			
Mano dominante:	**____ Derecha**	**____ Izquierda**	**____ Ambos**	
Empleador:	**Ocupacion:**	**E-Mail**		

Como escucho de nuestra oficina:_____

Nota especial: Si su lesion tiene que ver con un accidente de carro, pase a la pagina 2. Si no, utilice los espacios abajo para describer su lesion y/o dolor.

1. **Descripcion de la lesion o comienzo de el dolor**

   Escriba una descripcion completa de la lesion o el comienzo de el dolor en el espacion abajo.

2. **Que sintio despues de la lesion o comienzo de su condicion.**

   Escriba detalles de su condicion despues de la lesion o inmediatamente despues de el comienzo de el dolor.

HISTORIAL MEDICO

HA ESTADO ENVUELTO EN UN ACCIDENTE DE AUTO O DE TRABAJO ANTERIORMENTE?

_____

_____

ANTERIORMENTE, HABIA TENIDO ALGUNA LESION A EL AREA O AREAS QUE ESTAN EVUELTAS AHORA?

_____

HA TENIDO FRACTURAS DE HUESOS PREVIAS?_____

HA TENIDO SIRUGIAS PREVIAS?: _____

SUFRE DE ALGUNA CONDICION DE SALUD?: ____Si ____No SI LA CONTESTACION ES SI, EXPLIQUE:

_____

ESTA TOMANDO ALGUN MEDICAMENTO EN ESTE MOMENTO: ____Si ___No

SI LA CONTESTACION ES SI, DE UNA LISTA DE LOS MISMOS:_____

HAVE YOU EXPERIENCED ANY BOWEL OR URINARY CHANGES SINCE THIS CONDITION BEGAN? Explain

_____

ESTABA SALUDABLE ANTES DE LA PRESENTE LESION: ____Si ____No

SI NO, EXPLIQUE: _____

MUJERES: Esta usted embarazada? _____Si _____No Fecha de su ultimo periodo _____

DOCTOR DE CABECERA/NOMBRE/TELEFONO	**DOCTOR DE CASO DE COMPENSACION AL EMPLEADO**

HISTORIAL SOCIAL

USTED UTILIZA: _____ Medicamentos recetados _____ Tabacco _____ Alcohol _____ Drogas recreacionales

SI LA CONTESTACION ES SI, EXPLIQUE:_____

ESTADO MARITAL _____C ____S ____V ____D NINOS EN LA CASA? _____

HISTORIAL OCUPACIONAL

ESTABA EMPLEADO CUANDO TUVO SU LESION?: _____ Si _____ No

FALTO AL TRABAJO POR SU LESION: _____ Si _____ No _____ Fecha

SI NO, EL TRABAJO EMPEORA SU SINTOMAS? _____ Si _____ No

EXPLIQUE: _____

_____

I hereby give authorization for my medical results/records to be disclosed to my other doctors that I have listed on this form. I hereby give consent for treatment to Brandon Chiropractic and Massage.

I hereby certify that the information I have given is true to the best of my knowledge.

SIGNATURE _____ DATE _____

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave., Brandon, FL 33511

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative (please print)

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave., Brandon, FL 33511

FINANCIAL POLICY

IT IS THE POLICY OF THIS OFFICE THAT ALL FEES FOR SERVICES ARE PAID WHEN SERVICES ARE RENDERED UNLESS INSURANCE BENEFITS HAVE BEEN VERIFIED

INSURANCE ASSIGNMENT

NO insurance will be accepted until all insurance information has been obtained and coverage has been verified.

The patient is responsible for the co-payment on a weekly basis once the deductible has been satisfied. In the event that the insurance carrier rejects your claim, or the amount paid is less than expected, the patient is responsible for the bill at that time.

This office **DOES NOT** promise that an insurance will pay, nor does this office promise that the insurance company will pay appropriately for the fee charges. Our office **WILL NOT** enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.

CASH PATIENT

Payment is due when services are rendered. If payment cannot be made, other financial arrangements must be made **PRIOR TO THE START OF TREATMENT**.

I HEREBY AUTHENTICATE THAT I HAVE READ AND UNDERSTAND THE FOREGOING POLICY.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS DATE

Brandon Chiropractic and Massage

654 E. Bloomingdale Ave., Brandon, FL 33511

PATIENT REQUEST FOR TRANSFER OF RECORDS

I HEREBY AUTHORIZE THE RELEASE OF MY X-RAYS AND/OR RECORDS OR COPIES OF SUCH AND REQUEST THAT THEY BE TRANSFERRED TO:

Brandon Chiropractic and Massage
654 E. Bloomingdale Ave.
Brandon, FL 33511

Telephone Number (813) 685-5200
Fax Number (813) 654-8758

PATIENT NAME _____

DATE OF RECORDS _____

DATE OF BIRTH _____

SOCIAL SECURITY _____

THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPPA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(10) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITIED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVES.

THANK YOU FOR YOUR CONSIDERATION IN PROCESSING THE ABOVE REQUEST IF YOU HAVE ANY QUESTIONS OR NEED ANY FURTHER INFORMATION, PLEASE DO NOT HESITATE TO CONTACT OUR OFFICE.

_____ _____

PATIENT SIGNATURE DATE