PATIENT BASIC INFORMATION

Cash **Date: _____**

Last Name:	**First Name:**			**MI:**
Address:		**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		**Social Security Number:**	
Date of Birth:	**Date of Injury/Onset:**			
Dominant Hand:	**____ Right ____ Left ____ Both**			
Employer:	**Occupation:**	**E-Mail**		

How did you hear about our office:_____

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. **Description of Accident / Injury / Onset**

   Enter a full description of the accident, injury or onset in the space below.

2. **Your condition during and immediately after injury / onset**

   Enter the details of your condition during and immediately after your injury / onset.

HISTORY

HAVE YOU EVER BEEN INVOLVED IN A WORK RELATED OR AUTO ACCIDENT?

_____

_____

PRIOR TO THIS, HAVE YOU EVER RECEIVED ANY INJURY TO THE AREA(s)NOW INJURED?

_____

HAVE YOU EVER HAD ANY BROKEN BONES? _____

HAVE YOU EVER HAD ANY SURGERIES: _____

DO YOU HAVE ANY PRESENT HEALTH CONDITION: ____Yes ____No IF YES, PLEASE EXPLAIN:

_____

DO YOU TAKE ANY MEDICATION AT THIS TIME: ____Yes ___No

IF YES, PLEASE LIST: _____

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

_____

DIDYOU ENJOY GOOD HEALTH PRIOR TO THIS INJURY / ONSET: ____Yes ____No

IF NO, PLEASE EXPLAIN: _____

FEMALE: Are you, or could you be pregnant? _____Yes _____No Date of Last Period _____

FAMILY DOCTOR NAME & ADDRESS	**WORK / AUTO ACCIDENT DOCTORS NAME & ADDRESS**

SOCIAL HISTORY

DO YOU USE: _____ Prescription drugs _____ Tobacco _____ Alcohol _____ Recreational drugs

IF YES, PLEASE LIST:_____

MARITAL STATUS _____M ____S ____W ____D HOW MANY CHILDREN IN HOME _____

OCCUPATIONAL HISTORY

WERE YOU EMPLOYED WHEN YOUR CONDITION OCCURRED: _____ Yes _____ No

DID YOU STOP WORKING DUE TO YOUR CONDITION: _____ Yes _____ No _____ Date

IF NO, DOES WORK MAKE YOUR CONDITION WORSE? _____ Yes _____ No

IF YES, PLEASE EXPLAIN: _____

_____

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