CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 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

Attorney Name (if applicable) _____

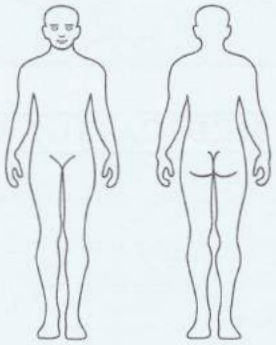
5 PATIENT CONDITION

Reason for Visit _____

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.



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 ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant 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

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address 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 _____

Dental X-Ray _____ 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	Diabetes ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Sexually Transmitted Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Other _____
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	
Chicken Pox ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	
		Rheumatoid Arthritis ☐ 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		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

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Legionnaire / Board Certified Diplomate of Philosophy
Fellow International Academy Chiropractic Neurology

ASSIGNMENT OF PAYMENT / RELEASE OF INFORMATION / HIPAA

By my signature below, I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical insurance benefits for services to be paid directly to **North Shore Chiropractic**. I accept responsibility for payment of any co-payments, co-insurances or deductibles and for full payment of charges should my insurance company determine that my condition or the services provided are not covered by my policy, or if for any reason, refuse to pay my claim.

Further, I hereby authorize **North Shore Chiropractic** and all of its representatives to act on my behalf for matters pertaining to my healthcare at this office. This would include releasing and discussing information required by state and/or federal public health law in order to process any health care insurance claim or litigation matters to and with any attorney or court requesting same. This may also include local, county and/or state representatives and their agents.

This office and, therefore, any of the above-mentioned entities adhere to standard HIPAA and OIG compliance for patient confidentiality and privacy rules.

_____ _____

Date **Signature of Patient or Authorized Representative**

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all charges for services rendered, which may include interest accrued if payments are not made within 30 days and, in the case of non-payment, all costs associated with collection of the debt.

_____ _____

Date **Signature of Patient or Authorized Representative**

MEDICARE PATIENTS ONLY: By my signature below, I authorize the release of any medical and non-medical information necessary to process this claim with Medicare or any other health insurance under which I am covered. I understand that:

1) I will pay the Medicare fee at the time of my visit and that Medicare will reimburse me directly. Secondary insurance payments may be paid directly to me and, if so, I will write my personal check for that amount to Dr. Gary DiBenedetto OR pay that amount in cash OR pay that amount by my credit card within ten days of receipt;
2) I will provide all "Explanations of Benefits" (EOBs) received with those payments; and
3) I accept responsibility for payment in full of the annual deductible, the coinsurance, and any non-covered services under Medicare.

_____ _____

Date **Signature of Patient or Authorized Representative**

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CONSENT OF CARE

Inherent to all of chiropractic care is the use of the doctor's skillful hands, and that of his assistant's, to palpate or touch areas of the spine including the neck, back, lower back, buttock and the pelvis area. "Palpating" or touching exposed skin is necessary to properly assess the patient's need for chiropractic care.

This information is being given to you at this time to inform you in advance of some of the chiropractic treatments the doctor will be using in order to provide our patients with the best possible care. Follow up care by chiropractic assistants in our office may also require physical contact to exposed skin in order to apply pressure points or other hands-on procedures.

Please inform our staff immediately if treatments requiring physical contact are not wanted since we will not be able to provide chiropractic care without physical contact. Instead, every effort will be made to refer you to someone better able to address your individual concerns.

Please sign below to indicate that you understand and accept the conditions described above.

_____ _____

Date: **Patient / Responsible Party Signature**

_____ _____

Date: **Witness Signature**

X-RAY CONSENT

Prior to having x-rays, please read and initial all that applies and sign at the bottom:

_____ By my signature below, I do agree to have the recommended x-rays performed in this office.

_____ By my signature below, I do hereby state that I do not want the recommended x-rays performed at this particular time.

_____ By my signature below, I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected at this particular time.

_____ **Medicare Patients Only:** My signature below indicates that I have been advised by this office that x-rays performed by a chiropractor are excluded from Medicare coverage and I accept responsibility for payment of the charges.

_____ **Major Medical Patients Only:** Should it be that for any reason x-rays are not covered by my insurance policy, my signature below indicates that I accept responsibility for payment of the charges.

_____ _____

Date: **Patient / Responsible Party Signature**

_____ _____

Date: **Witness Signature**

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Electronic Health Records Intake Form

In compliance with the Medicare requirements for the government EHR incentive program.

Name: _____ **E-Mail Address:** _____

Preferred Method of Communication for reminders (circle one): Phone / E-Mail / Mail

DOB: ___/___/___ **Gender:** Male / Female **Preferred Language:** _____

Smoking Status (circle one): Every Day / Occasional / Former / Never

CMS requires providers to report both race and ethnicity.

Race (circle one): Asian / Black (African American) / White (Caucasian) / Other / Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Non-Hispanic or Latino / Decline to Answer

Are you a Diabetic? Yes / No **Do you have Hypertension** (high blood pressure)**?:** Yes / No

Are you currently taking any medication? (Please include any over-the-counter medications.)

Medication Name	**Dosage & Frequency** (i.e., 5mg once/day)

Do you have any medication allergies?:

Medication	**Reaction**	**Onset Date**	**Comments**

_____ I choose to decline receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature of chiropractic care.

Patient / Responsible Party Signature: _____ **Date:** _____

For Office Use Only

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____

298 Canal Road, Port Jefferson Station, NY 11776, P 631-928-0192, F 631-928-0253
www.NorthShoreChiropractic.com

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NOTICE OF PRIVACY FOR PATIENT'S PROTECTED HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies (medical, no-fault, worker's compensation) to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal public health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing, at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is the Office Manager and can be reached at 631-928-0192 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (print) Signature of Patient/Legal Representative Date