

PINES FAMILY CHIROPRACTIC CENTER

9841 Pines Blvd. • Pembroke Pines, Florida • 33024



CONFIDENTIAL PATIENT ENTRANCE INFORMATION
PLEASE PRINT

Date: ____/____/____
Name: _____
SS#: ____ - ____ - ____ Home Phone: _____
Cell Phone: _____ Email: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Birth Date: ____/____/____ Age: _____ Sex: M F Marital Status: M S D W
Occupation: _____ Employed By: _____
Work Phone: _____ Work Address: _____
Spouse's Name: _____ Spouse's Employer: _____
Emergency Contact: _____ Phone: _____

List your chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Have you ever been to a Chiropractor before? Yes No If yes, when?

List doctors consulted for these conditions:

1. _____ Address/Phone: _____
2. _____ Address/Phone: _____

If this is an injury:

1. Work-related? Yes No If yes, have you reported it to your employer?
2. Related to an motor vehicle crash? Yes No
If this is due to a crash, fill out the appropriate report forms which will be provided to you.

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES RENDERED.

NAME OF PARENT OR FINANCIALLY RESPONSIBLE PERSON: _____

2. THE FEE PAID FOR CHIROPRACTIC X-RAYS IS FOR STRUCTURAL ANALYSIS ONLY.
3. METHOD OF PAYMENT YOU PLAN TO TAKE CARE OF TODAY'S CHARGES
Cash____ Check____ Visa/MC____
4. Do you have any type of insurance? Yes No

FEMALES: Are you pregnant? Yes No Not Sure

Please continue on the back side . . .

Insurance Information

Please provide a copy of your insurance card, driver's license and any secondary insurance information to our front desk.

Insurance Company: _____ Phone #: _____
Member I.D.: _____ Grp. #: _____
Insured's Name: _____ Sex: M F
Insured's Birth Date: ____/____/____ Relationship to Insured: _____

Patient Acknowledgment: I have been given a copy of Pines Family Chiropractic's Notice of Privacy Practice, version effective April 14, 2003. By signing this form, I give my consent to this office's use and disclosure of protected health information about myself for treatment, payment and health care operations, as well as those purposes set forth in the Notice of Privacy.

Signature _____ Date _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance in my account for any professional services rendered.

Furthermore, I understand that Pines Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Pines Family Chiropractic 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, any fees for professional services rendered me will be immediately due and payable.

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or the above information.

RELEASE & ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Signature: _____ Date _____
Print Name: _____
Spouse's Name or Guardian Signature: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants Blood Thinners Insulin Other(s) _____

Do you have or have you ever had any of the following diseases or conditions?

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Heart Surgery/Pacemaker	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Valves
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Shingles	<input type="checkbox"/> Cancer
<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Emphysema/Glaucoma	<input type="checkbox"/> Anemia
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes/Tuberculosis	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Lower Back Problems	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Nose Bleeds

Please list any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any PAST serious accidents with dates: _____

Family Health History: _____

Do you: Take supplements or vitamins? Y N Exercise? Y N If yes, describe: _____

Do you smoke? Y N If yes, how much? _____ How long? _____

Are you wearing: Heel lifts Sole lifts Inner Soles Arch Supports Orthotics

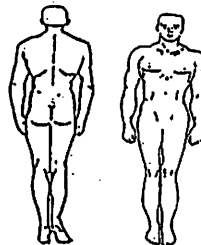
Current Weight: _____ Height: _____

Women: Are you taking Birth Control? Y N Are you pregnant? Y N If yes, how far along? _____ Are you nursing? Y N

All Patients: Please Mark Problem Area(s):

Is the Pain:

Sharp/Stabbing Aching
 Pins & Needles Burning



I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____