

**Windmill Health Center**  
**17160 Royal Palm Blvd., Suite 1 • Weston, FL 33326**  
**Dr. Rick Behar • Dr. Marc Browner**

CONFIDENTIAL PATIENT ENTRANCE INFORMATION

PLEASE PRINT

DATE: \_\_\_/\_\_\_/\_\_\_  
NAME: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone #: \_\_\_\_\_  
CELL/PAGER #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  
BIRTH DATE: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_ SEX: M F MARITAL STATUS: M S D W  
OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_ WORK ADDRESS: \_\_\_\_\_  
SPOUSES NAME: \_\_\_\_\_ SPOUSES EMPLOYER \_\_\_\_\_  
IN CASE OF AN EMERGENCY: \_\_\_\_\_ PHONE #: \_\_\_\_\_

Have you ever seen a chiropractor? Yes No

HOW WERE YOU REFERRED TO OUR OFFICE? \_\_\_\_\_

List Chief Complaints in order of severity:

1. \_\_\_\_\_ For how long? \_\_\_\_\_
2. \_\_\_\_\_ For how long? \_\_\_\_\_
3. \_\_\_\_\_ For how long? \_\_\_\_\_

List any doctors consulted for these conditions?

1. \_\_\_\_\_ Address/ Phone: \_\_\_\_\_
2. \_\_\_\_\_ Address/ Phone: \_\_\_\_\_

**If this is an injury:**

Work-related? Yes No If yes, have you reported it to your employer?

Related to an auto accident? Yes No If this is an accident, please inform us and we will provide you the necessary forms.

**Females: Are you pregnant? Yes No Not Sure**

1. All first visit charges are payable when services are 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 use to take care of today's charges: Cash Check Visa/MC
4. Do you have any type of insurance? Yes No

Please continue on the back side, read, then **sign in the center and at the bottom.**

## Chiropractic Insurance Information

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

COMPLETE ONLY IF PATIENT IS NOT THE INSURED

Insured's Name: \_\_\_\_\_ Sex: M F  
Marital Status: M S D W Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patients relationship to insured: \_\_\_\_\_

**FOR BLUE CROSS/BLUE SHIELD PATIENTS:** As a courtesy to you, we will file your claims on your behalf. Please be advised that all insurance monies will be **paid directly to you/the insured. You will be responsible for forwarding the checks to our office.** Furthermore, you will allow Windmill Chiropractic to call BCBS to verify insurance payment and allow BCBS to disclose the amount of payment for services rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Acknowledgement:** I have been given a copy of Windmill 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 Windmill 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 Windmill 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, fees and legal costs for collection efforts.

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 ever had any of the following diseases or conditions? (Circle)

Heart Attack / Stroke

Congenital Heart Defect

Alcohol / Drug Abuse

HIV / Aids

Frequent Neck Pain

High / Low Blood Pressure

Severe / Frequent Headaches

Fainting / Seizures / Epilepsy

Diabetes / Tuberculosis

Lower Back Problems

Digestive Problems

Heart Surgery / Pacemaker

Mitral Valve Prolapse

Venereal Disease

Shingles

Emphysema / Glaucoma

Psychiatric Problems

Kidney Problems

Sinus Problems

Difficulty Breathing

Artificial Bones / Joints

Ringings in Ears

Heart Murmur

Artificial Valves

Hepatitis

Cancer

Anemia

Rheumatic Fever

Ulcers / Colitis

Asthma

Chemotherapy

Arthritis

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 / How Much? \_\_\_\_\_ How Long? \_\_\_\_\_

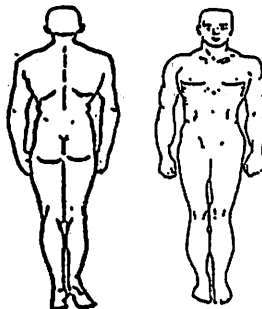
Are you wearing: Heel Lifts, Sole Lifts, Inner Soles, Arch Supports, Orthotics? \_\_\_\_\_

List your current weight: \_\_\_\_\_ and height, \_\_\_\_\_ Ft. in. \_\_\_\_\_

**For Women:** Are you taking Birth Control? Y N Are you pregnant? Y N If yes, how long? Nursing? Y N

PLEASE MARK PROBLEM AREA(S):

Is the Pain:  
(Circle)      Sharp  
                  Pin & Needles  
                  Aching  
                  Stabbing  
                  Dull



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 \_\_\_\_\_