Confidential Patient Information

Patient Name: ______________________________ D.O.B.: __________ Sex: M F

Address: ______________________ City: ____________ State: ___ Zip: _______

Home ph: ______________ Cell ph: _____________ Preferred Number? Home Cell

Can we text you for appointment reminders? Yes No Cell Carrier: _____________

SS #: ________________ Marital Status: M S W D – Spouses Name: ____________

E-Mail Address: ________________________ Patient Occupation: ____________

Name & Address of Employer: ____

Person to contact in case of emergency:

Name: _______________________ Relation: ___________ Phone #: ___________

Who may we thank for referring you? ____________________________________

Insured Information:

Relationship of patient to insured: Self Spouse Child Other: ________________

Name of insured: ____________________________ D.O.B.: __________ Sex: M F

Phone #: ___________________ SS #: _______________ Marital Status: M S W D

Address: _____________________________ City: _________________________

State: ____ Zip: _________ Insured's place of employment: __________________

Primary Insurance:

Insurance Company: _______________________ Phone #: __________________

Policy #: ____________ Group #: _____________ Type: Medicaire / Major Medical

Secondary Insurance:

Insurance Company: _______________________ Phone #: __________________

Policy #: ____________ Group #: _____________ Type: Medicaire / Major Medical

Do you have a Flex spending or HSA Account? Yes No

I hereby authorize direct payment of medical benefits to the provider for services rendered by them. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf. A service charge of 1 ½% per month, 18% APR, will be added to all overdue accounts. I am also liable for all legal and collection fees. I understand that I am financially responsible for any balance not covered by my insurance.

I have read the above information and discussed it with my Doctor. I understand that I take full responsibility for alerting my Doctor to any physical condition, which would affect treatment.

New Patient History

Do you suffer from?

Headaches ____ Neck Pain ____ Arm/Shoulder Pain ____ Back Pain ____

Numbness ____ Hip or Leg Pain ____ Dizziness ____ Chest Pain ____

Have you had previous Chiropractic care? Y N How long ago? ______

Main Complaint: ____

Other Complaints: ____

How long have you had this condition? __________________________________

Have you had similar conditions in the past? ___________________________

Does this condition affect your work? YES NO

What aggravates this condition? ____

Other Doctors seen for this condition: __________________________________

Are you taking any medications? _______________________________________

What helps your symptoms? ____

Have you had any surgeries/falls/accidents? YES NO

Was it work related? YES NO Was it auto related? YES NO

Please describe when/what happened: ______________________________

____

Primary Care Physician name: ____________________ Last Exam Date: ______

I hereby state that the above information is true to the best of my knowledge, and take full responsibility to alerting the doctor to any physical conditions or changes in the condition.

Signed: ____ Date: _____________

HIPPA Privacy Act

Health Care Authorization Form

Patient Name: ______________________________________ Date of Birth: ______________

The patient identified above authorizes John Milone, D.C. and affiliated doctors practicing at Back 2 Health to use and/or disclose their protected health information in accordance with the following:

Specific Authorizations (Please initial all that apply)

____ I give permission to John Milone, D.C. to use my address and phone number to contact me with appointment reminders, missed appointment notification, holiday cards, newsletters, and other health related information.
____ If the office contacts me by phone, I give them permission to leave a voice message on my answering machine, or with any individual that answers my phone.
____ I give John Milone, D.C. permission to share my protected health information with my personal physician or any other doctor or health care provider involved in my treatment.
____ I give John Milone, D.C. permission to disclose any of my personal or clinical information necessary to my health insurance carrier(s) if needed to process claims made by their office for services rendered to me.
____ I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

This authorization shall not expire unless revoked in writing

This authorization is requested by John Milone, D.C. located at 5509 Merrick Rd., Massapequa, NY 11758 for its own use/disclosure of Protected Health Information. You have the right to refuse to sign this authorization. Under this law, we have the right to refuse treatment to you, should you choose not to disclose your Protected Health Information.

Right to Revoke Authorization

You have the right to revoke this authorization at any time, in writing. You may revoke this authorization by mail or by hand delivering a written notice to the Privacy Official designated by John Milone, D.C.. The written notice must contain the following information: **Your name and Date of Birth with a clear statement of your intent to revoke the authorization with your signature and the date.**
The revocation is effective immediately upon receipt of this letter. However, your written request to revoke your authorization for release of personal and clinical information to your health insurance company for services rendered will not go into effect until all dates of service previously rendered to you are paid for either by you personally or your insurance carrier.

Sign: ____ Date: ______________

REVIEW OF SYSTEMS

Please check all the apply:

General-
- □ Weight loss or gain
- □ Fatigue
- □ Fever or chills
- □ Weakness
- □ Trouble sleeping

Skin-
- □ Rashes
- □ Lumps
- □ Itching
- □ Dryness
- □ Color changes
- □ Hair and nail changes

Head-
- □ Headache
- □ Head injury
- □ Neck Pain

Ears-
- □ Decreased hearing
- □ Ringing in ears
- □ Earache
- □ Drainage

Eyes-
- □ Vision Loss/Changes
- □ Glasses or contacts
- □ Pain
- □ Redness
- □ Blurry or double vision
- □ Flashing lights
- □ Specks
- □ Glaucoma
- □ Cataracts
- □ Last eye exam

Nose-
- □ Stuffiness
- □ Discharge
- □ Itching
- □ Hay fever
- □ Nosebleeds
- □ Sinus pain

Throat-
- □ Bleeding
- □ Dentures
- □ Sore tongue
- □ Dry mouth
- □ Sore throat
- □ Hoarseness
- □ Thrush
- □ Non-healing sores

Neck-
- □ Lumps
- □ Swollen glands
- □ Pain
- □ Stiffness

Breasts-
- □ Lumps
- □ Pain
- □ Discharge
- □ Self-exams
- □ Breast-feeding

Respiratory-
- □ Cough
- □ Sputum
- □ Coughing up blood
- □ Shortness of breath
- □ Wheezing
- □ Painful breathing

Cardiovascular-
- □ Chest pain or discomfort
- □ Tightness
- □ Palpitations
- □ Shortness of breath with activity
- □ Difficulty breathing lying down
- □ Swelling
- □ Sudden awakening from sleep with shortness of breath

Psychiatric-
- □ Nervousness
- □ Stress
- □ Depression
- □ Memory loss

Gastrointestinal-
- □ Swallowing difficulties
- □ Heartburn
- □ Change in appetite
- □ Nausea
- □ Change in bowel habits
- □ Rectal bleeding
- □ Constipation
- □ Diarrhea
- □Yellow eyes or skin

Urinary-
- □ Frequency
- □ Urgency
- □ Burning or pain
- □ Blood in urine
- □ Incontinence
- □ Change in urinary strength

Vascular-
- □ Calf pain with walking
- □ Leg cramping

Musculoskeletal-
- □ Muscle or joint pain
- □ Stiffness
- □ Back pain
- □ Redness of joints
- □ Swelling of joints
- □ Trauma

Neurologic-
- □ Dizziness
- □ Fainting
- □ Seizures
- □ Weakness
- □ Numbness
- □ Tingling
- □ Tremor

Hematologic-
- □ Ease of bruising
- □ Ease of bleeding

Endocrine-
- □ Head or cold intolerance
- □ Sweating
- □ Frequent urination
- □ Thirst
- □ Change in appetite

Name: ________________________________ Sign: _____________________________Date: ________