Confidential Patient Information

Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name: _____ Date: _____
Address: _____ Town: _____ State: _____ Zip: _____
Email: _____Age: _____ Birthdate: _____ Marital Status: M S W D
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Emergency Contact Name/Relationship: _____ Phone: (____) _____
Occupation/Name of Employer: _____
Whom may we thank for referring you: _____

Health Information

Have you had previous chiropractic care? □ Yes □ No
Have you had similar conditions in the past? □ Yes □ No
When did this injury occur? _____ How long have you had this condition? _____
Main Complaint: _____
Other Complaints: _____
Does this condition effect your work? □ Yes □ No
Does this condition effect your family or social life? □ Yes □ No
What aggravates your symptoms? _____
What helps your symptoms? _____
Other doctors seen for this condition? _____
Are you taking any medication: □ Yes □ No If so, _____
Have you had and surgery, falls or accidents? □ Yes □ No When? _____
Please describe: _____

DO YOU SUFFER FROM?

	Yes	No			Yes	No
Abdominal Pain	□	□		Hip/Leg Pain	□	□
Anemia	□	□		Insomnia	□	□
Arm/Shoulder Pain	□	□		Irritability	□	□
Back Pain	□	□		Kidney Problems	□	□
Bladder Pain	□	□		Light Bothers Eyes	□	□
Chest Pain	□	□		Loss of Memory	□	□
Circulatory Issues	□	□		Loss of Balance	□	□
Cold Feet/Hands	□	□		Loss of Smell	□	□
Constipation/Diarrhea	□	□		Lung/Bronchial Disorder	□	□
Depression	□	□		Morning Fatigue	□	□
Diabetes	□	□		Neck Pain	□	□
Digestive Disorder	□	□		Nervousness	□	□
Dizziness	□	□		Numbness	□	□
Ear Ring/Buzz	□	□		Palpitation	□	□
Face Flushed	□	□		Pins and Needles in Arms/Legs	□	□
Fatigue/Fainting	□	□		Poor Memory	□	□
Female/Male Problems	□	□		Shortness of Breath	□	□
Fever	□	□		Sinus Trouble	□	□
Headache	□	□		Swollen Joints	□	□
Head Seems Heavy	□	□		Tension	□	□
Heart Trouble	□	□		Upset Stomach	□	□
High/Low Blood Pressure	□	□			□	□

Insurance Information

A work-related injury? □ Yes □ No
Date: _____ Time: _____ Location: _____
Description of accident: _____
_____
_____
Workers Compensation Case #: _____
Insurance Company: _____ Insurance co. case #: _____
Employers Name: _____ Address: _____
Hospitalized? □ Yes □ No Name of Hospital: _____
X-rays taken? □ Yes □ No Other doctors seen: _____
Are you working now? □ Yes □ No Time lost form work: _____ to _____
An automobile accident? □ Yes □ No
Date: _____ Time: _____ Location: _____
Auto Accident? □ Yes □ No Auto Collision? □ Yes □ No
Description of accident: _____
_____
_____
If auto accident, were you: □ Driver □ Passenger □ Pedestrian
If auto collision, were you hit from: □ Behind □ Right Side □ Left Side □ Front □ Auto parked
Did your car strike the other(s) involved? □ Yes □ No □ Undetermined
Did the other car(s) strike yours? □ Yes □ No □ Undetermined
As a result of the accident, were traffic citations issued to you? □ Yes □ No
To the driver of the other car(s)? □ Yes □ No
To the driver of the car you were in? □ Yes □ No
List the extent of injuries as you know them: _____
_____
_____
Did you require post-accident hospitalization? □ Yes □ No
Are you working now? □ Yes □ No Time lost form work: _____ to _____
Insurance Companies Involved:
My Company: _____
Company of person responsible for injuries: _____
Has an Insurance adjuster regarding this claim contacted you? □ Yes □ No
Do you have an attorney who advised you in this care? □ Yes □ No
Are you covered by Medicare? □ Yes □ No
Medicare Number: _____

Do you have major medical insurance? □ Yes □ No
Company: _____ ID Number: _____Phone Number: (___) _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Martin Marmorale 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 Dr. Martin Marmorale will be credited to my account on 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Date: _____
Guardian or Spouses Signature: _____ Date: _____

Notice of Privacy Practices

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. It also discusses the uses and disclosure we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of the notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By the law, consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy.

Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent. Specific authorization is required to disclose protected information in non-routine circumstance, such as to your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

We may contact you to provide appointment reminders for treatment or medical care, and also to recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or the Secretary of Health.

The law requires that you acknowledge receipt of this notice; this has been included on the signature release on the bottom of this form.

You have the right to inspect and copy your health information; you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

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I acknowledge that I have read and understand the above Notice of Privacy Practices.

Signature: _____ Date: _____
Relationship to Patient: _____
Provider: _____