CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Work Telephone _____ # Children _____ Spouse's Name _____

Cell # _____ Whom may we thank for referring you _____

Name and Address of Employer _____ Occupation _____

HEALTH INFORMATION

Have you had previous chiropractic care? ☐ Yes ☐ No

Main Complaint _____

Other Complaints _____

Are you pregnant? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No If yes, what? _____

Sign here to authorize x-rays and necessary tests _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Does this condition effect your family or social life? ☐ Yes ☐ No

What aggravates this condition? _____

_____

Other Doctors seen for this condition _____

_____

What helps your symptoms? _____

Have you had any surgery, falls or accidents? ☐ Yes ☐ No

When? _____ Please describe _____

_____

Date of last physical examination _____

INSURANCE INFORMATION

Is this condition due to:
A work-related injury? ☐ Yes ☐ No An automobile accident? ☐ Yes ☐ No
If you answer yes to either of the above questions, please complete other side of form.

Do you have Major Medical Health Insurance? ☐ Yes ☐ No

Company _____

Address _____

Do You Suffer From:

	YES	NO
Headaches	☐	☐
Neck Pain	☐	☐
Arm or Shoulder Pain	☐	☐
Back Pain	☐	☐
Hip or Leg Pain	☐	☐
Chest Pain	☐	☐
Abdominal Pain	☐	☐
Sinus Trouble	☐	☐
Heart Trouble	☐	☐
Palpitation	☐	☐
Circulatory	☐	☐
High or Low Blood Pressure	☐	☐
Female Problems	☐	☐
Prostate Disorder	☐	☐
Kidney Problems	☐	☐
Bladder Problems	☐	☐
Lung or Bronchial Disorders	☐	☐
Digestive Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
General Fatigue	☐	☐
Morning Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Fontanarosa Chiropractic Wellness Center 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 Fontanarosa Chiropractic Wellness Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian or Spouse's Signature _____ Date: _____

Information Taken By: _____ Date: _____

Complete only for:

JOB INJURY INFORMATION: Date _____ Time _____ Location _____

Description of accident _____

_____

_____

Workman's Compensation Case # _____

Insurance Company _____ Address _____

Insurance Company Case # _____

Employer's Name _____ Address _____

Hospitalized? _____ Name of Hospital _____ X-rays taken _____

Other Doctors seen _____

Are you working now? _____

Time lost from work _____ to _____ (dates)

_____

Complete only for:

ACCIDENT INFORMATION: Date _____ Time _____ Location _____

How did accident occur? ☐ Auto Collision ☐ Other _____

_____

_____

If auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was Parked

Did your car strike the other(s) involved? ☐ Yes ☐ No

Or did the other car 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? ☐ Yes ☐ No

To the driver of your car? ☐ Yes ☐ No

List the extent of the injuries as you know them _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since accident:

☐ Headache	☐ Dizziness	☐ Light Bother Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatique	☐ Loss of Smell	☐ _____

Symptoms other than above _____

Have you lost any days of work? ☐ Yes ☐ No Dates: _____

Insurance Companies involved:

My Company _____

Company of person responsible for injuries _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney that has advised you in this care? ☐ Yes ☐ No

Name _____

Address _____

Telephone: _____

PAIN DIAGRAM

PATIENT NAME:_____TODAY'S DATE:_____

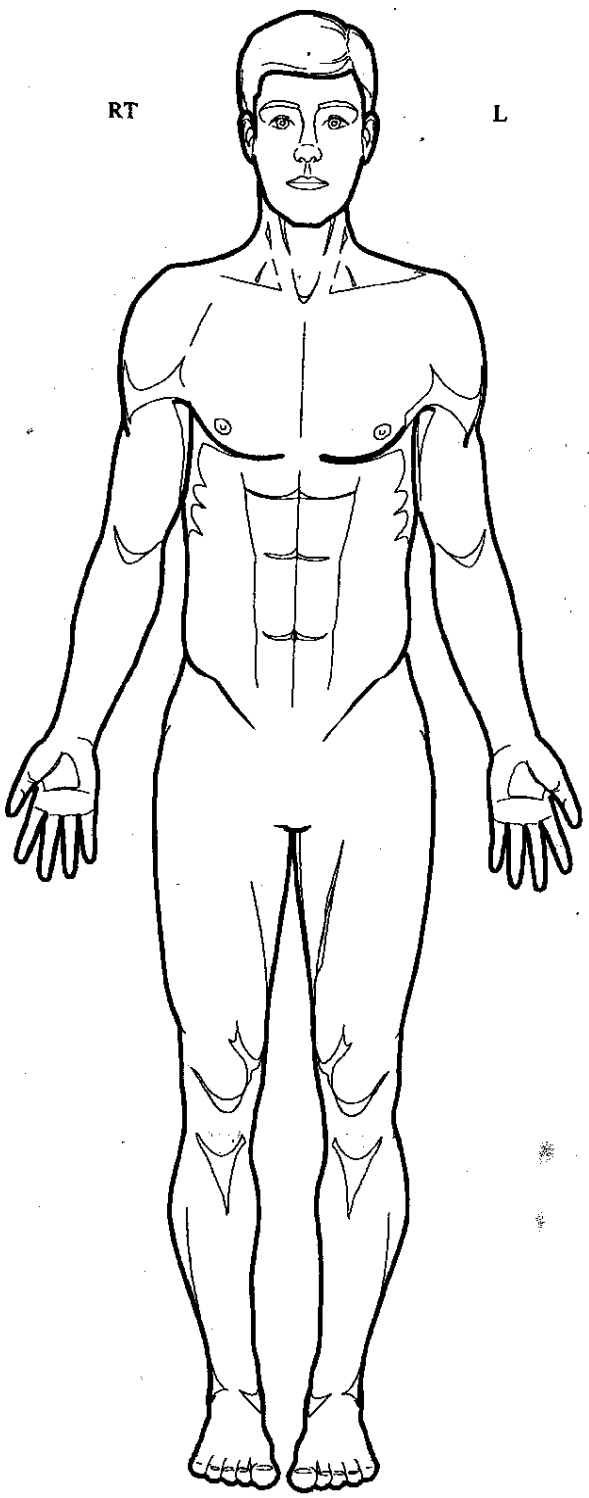
PLEASE COMPLETE THE FOLLOWING "***PAIN DIAGRAM***" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (**P**)
TINGLING (**T**)
NUMBNESS (**N**)
BURNING (**B**)
STIFFNESS (**S**)

PATIENT'S SIGNATURE:_____

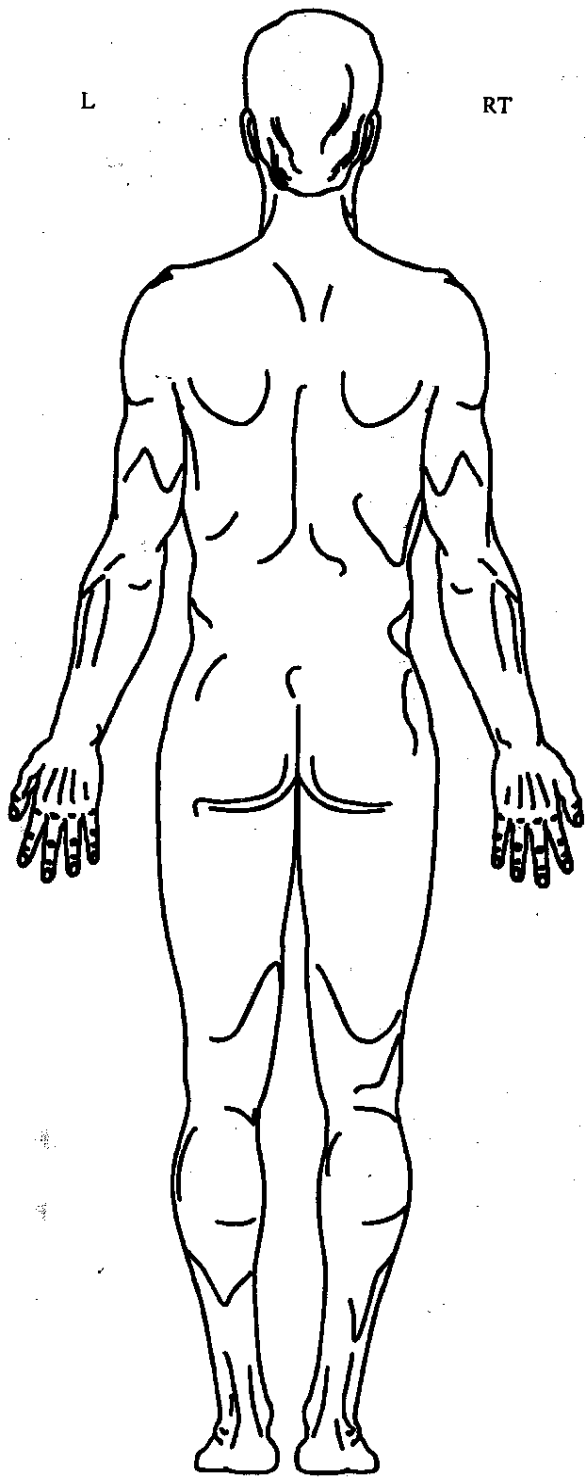
FRONT

RT L



BACK

L RT



Fontanarosa Chiropractic Wellness Center

Privacy Policy Authorization to use or disclose Protected Health information

In the course of your care as a patient at Fontanarosa Chiropractic Wellness Center we may use or disclose health released information about in the following ways:

□ Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

□ Your health care records as well as your billing records maybe disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.

□ Your name, address, phone number, and your health care record may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that maybe of interest to you.

□ You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have right to confidential communication and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and maybe required to use or disclose your health information without your authorization in these following circumstances:

□ If we provide health care services to you in an emergency.

□ If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

□ If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

□ If we if we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclose of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive medical and/or chiropractic treatment from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than you home or, if you would like the information in a specific please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and health information therein. We are also required to provide you with this notice of our privacy policy practice with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the charges. Any change in our privacy notice will apply for all of your health information in our files.

If you would like further information or have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct complaint to: **Dr. Domenic Fontanarosa.**

You also have the right to lodge a complaint with the secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of _____. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledge that I have received a copy of this notice.

Name (Print Please)

_____

Patient'sSignature_____Date_____

Guardian's Signature _____ Date_____

Signed form received from_____ Date_____

274 Lafayette Avenue, Hawthorne, NJ 07506, ph(973)423-9600 fax(973)423-0403