CUTITTA CHIROPRACTIC

NEW PATIENT HEALTH HISTORY FORM

In order to provide you with the best possible wellness care, please complete this form. All information is strictly **confidential**.

PATIENT DATA

Name: **Gender:**

Height: **Weight:**

Race: **Ethnicity:**

Birth Date: **Social Security #:**

PATIENT CONTACT INFORMATION

Street Address: **Primary Phone Number:**

(Circle one: Cell / Home / Work)

City: **State:** **Zip:** May we leave a message on this phone? ❑ Yes❑ No

Occupation: I would like to opt out of text message reminders ❑

Employer: **Secondary Phone Number** *(optional)*:

Referred by: *(how did you hear about us?)* (Circle one: Cell / Home / Work)

Relationship Status *(circle one):* May we leave a message on this phone? ❑ Yes❑ No

Single **Married** **Divorced** **Email Address:**

Widowed **Separated** **Other** *Your email will not be shared with any 3rd parties*

Spouse/Partner's Name: **Spouse/Partner's Occupation:**

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: Emergency Contact Relationship:

Emergency Contact Phone Number: **May we release confidential medical information to this person?**
❑ Yes❑ No

INSURANCE INFORMATION

Do you have Health Insurance? ❑ **Yes** ❑ **No** **If yes, name of company:**

Do you have an HSA or FSA? ❑ **Yes** ❑ **No** **If yes, would you like us to use these funds?** ❑ Yes ❑ No

If you have been in an auto accident, please fill out the following information

Auto Insurance company name: **Auto Insurance Adjustor or contact name:**

Phone Number: **Claim number:**

PATIENT CONSENT

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. If I fail to remit payment for charges due I understand that my information may be shared with credit collections services to ensure prompt payment.

Patient's Signature **Date:**

Guardian's Signature (if a minor) **Date:**

CUTITTA CHIROPRACTIC

Patient's Name **Patient Date of Birth:**

CURRENT COMPLAINT

Nature of Injury: ❑ **Auto Accident** ❑ **Work Accident** ❑ **Other** **Date of Injury:**

Please describe your injury below: **Date Symptoms Appeared:**

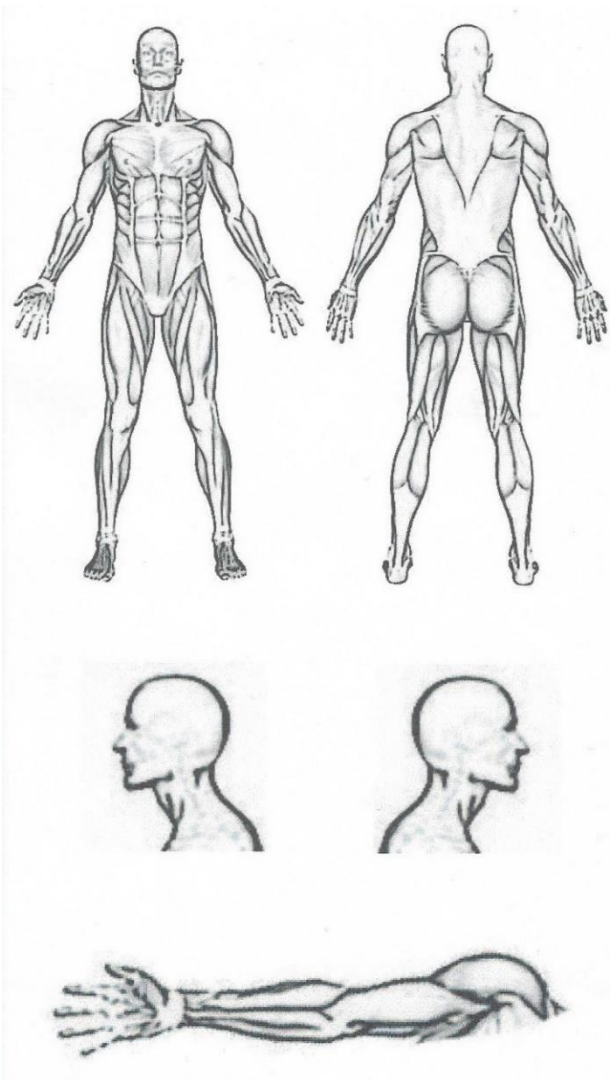
Have you ever had the same condition? ❑ **Yes** ❑ **No** **If yes, when?**

List of other practitioners seen for this condition:

Have you ever been under chiropractic care (for this or other conditions? ❑ **Yes** ❑ **No** **If yes, please describe:**

Please mark on this diagram using the following letters to indicate the TYPE and LOCATION of the symptoms you are currently experiencing:

A = Ache B = Burning	**N = Numbness** **O = Other**	P = Pins & Needles S = Stabbing



Have you ever suffered from:
(please circle all that apply)

Alcoholism	*Excessive Menstruation*	*Nosebleeds*
Allergies	*Eye Pain/ Difficulties*	*Pacemaker*
Anemia	*Fatigue*	*Polio*
Arteriosclerosis	*Frequent Urination*	*Poor Posture*
Arthritis	*Headache*	*Prostate Trouble*
Back Pain	*Heart Disease*	*Sciatica*
Breast Lump	*Hemorrhoids*	*Shortness of Breath*
Bronchitis	*High Blood Pressure*	*Sinus Infection*
Bruise Easily	*Hot Flashes*	*Sleep Problems/ Insomnia*
Cancer	*Irregular Cycle*	*Spinal Curvatures*
Chest Pains	*Irregular Heart Beat*	*Stroke*
Cold Extremities	*Kidney Infection*	*Swelling of Ankles*
Constipation	*Kidney Stones*	*Swollen Joints*
Cramps	*Loss of Balance*	*Thyroid Condition*
Depression	*Loss of Memory*	*Tuberculosis*
Diabetes	*Loss of Smell*	*Ulcers*
Digestion Problems	*Loss of Taste*	*Varicose Veins*
Dizziness	*Neck Pain or Stiffness*	*Venereal Disease*
Ears Ring	*Nervousness*	*Other*

CUTITTA CHIROPRACTIC

Patient's Name **Patient Date of Birth:**

MEDICAL HISTORY

Have you been treated for any conditions in the last year? ❑ Yes ❑ No

If yes, please describe:

Date of last physical exam: **PCP Name/Practice:**

Is there a chance you are pregnant? ❑ Yes ❑ No **Number of children you have:**

Have you had X-rays / MRI / CT Scans taken? **If yes, where and when were those scans taken?**

Please list any medications, vitamins, minerals or supplements you are taking: *if you need additional space please use the back of this form*

Medication/Supplement name	Dosage	Condition it is treating

Please list any allergies you have to medications:

Your habits…	None	Light	Moderate	Heavy	Notes
Alcohol	❑	❑	❑	❑	
Drugs	❑	❑	❑	❑	
Sleep	❑	❑	❑	❑	
Exercise	❑	❑	❑	❑	
Water	❑	❑	❑	❑	

Have you ever…	Yes	No	Please list details
Broken bones?	❑	❑	
Been hospitalized?	❑	❑	
Been in an auto accident?	❑	❑	
Had sprains/Strains?	❑	❑	
Been struck unconscious?	❑	❑	
Had surgery?	❑	❑	

Please answer the following:	Yes	No	Please let us know any details
Do you experience pain every day?	❑	❑	
Do your symptoms interfere with everyday life?	❑	❑	
Does pain wake you up at night?	❑	❑	
Are your symptoms worse during certain times of day?	❑	❑	
Do changes in the weather affect your symptoms?	❑	❑	
Do particular activities aggravate your symptoms?	❑	❑	

Smoking Status:

❑Current everyday smoker ❑Current some day smoker ❑Former smoker ❑Never smoker

FAMILY HISTORY

Family Member	Present and past health conditions:
Mother	
Father	
Siblings	
Maternal Grandparents	
Paternal Grandparents	
Other:	

CUTITTA CHIROPRACTIC

Patient's Name **Patient Date of Birth:**

ASSIGNMENT OF BENEFITS

Authorization for release of information and designation of authorized representative

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

The undersigned hereby authorizes Cutitta Chiropractic (hereinafter "the Provider") to file on my behalf for payment of any medical benefits arising out of any insurance or health plan benefits and hereby assign the benefits to the Provider. I certify that the information reported with regard to my insurance coverage, health care benefits and medical history is accurate and complete. I understand that I am liable for payment to the Provider for all co-insurance, co-pays and deductibles as required by my insurance or health benefits plan and I also acknowledge that I am responsible for payment of any charges not covered by my insurance or health benefits plan. Payment is required at the time services are rendered unless other payment arrangements are made, in advance.

DESIGNATION OF AUTHORIZED REPRESENTATIVE

The undersigned also designates the Provider to the fullest extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") as provided in 29 CFR 2560-503-1(b)(4) and under any applicable state and federal law to pursue claims and appeals on my behalf and exercise all rights connected with my health care benefit plan or insurance policy including but not limited to initial claims determinations, appeals of any benefit determinations, obtaining records and related plan documents, claiming on my behalf medical or other health care benefits, pursuing insurance or plan reimbursement and to pursue any other applicable remedies as may be necessary and with regards to my health benefit plan or insurance policy along with any incidental powers and duties to effectuate same.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned authorizes the Provider to release any medical or other information necessary to determine benefits to my insurance carrier, employer, plan administrator, or any other payer including any information regarding my illness and treatments and for the processing of benefits or insurance claims generated in the course of examination or treatment.

If a Worker's Compensation claim

The undersigned hereby authorizes _____ *(employer)* to furnish to the Provider a copy of all health care plan documents or information requested by the Provider and pursuant to 29 U.S.C. § 1024(b)(4), which includes but is not limited to the latest summary plan documents, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments.

REVOCATION AND ACKNOWLEDGEMENT

A photocopy of this authorization shall be considered the same as the original and can be used to process insurance or health benefit claims. The undersigned acknowledges that he/she has the right to revoke this authorization and designation of authorized representative, in writing, by sending notification to the Provider; however, the undersigned understands that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient's Signature **Date:**

Guardian's Signature *(if required)* **Date:**

CUTITTA CHIROPRACTIC

Patient's Name **Patient Date of Birth:**

INFORMED CONSENT

The determination of an appropriate plan of chiropractic/physical rehabilitation management for neuromusculorskeletal conditions may involve or include the utilization of orthopedic, neurologic and physical performance testing and physical, manipulative and exercise/rehabilitative therapies. Should these procedures be deemed appropriate in your case, you will be evaluated by the doctor to determine if you have any conditions that indicate you should not engage in any particular test or therapeutic procedure.

I, the undersigned, understand that, as with any form of physical activity or exercise, orthopedic, neurologic and physical performance testing and physical, manipulative and exercise/rehabilitative therapies carry with them a small inherent risk of injury which includes but is not limited to minor strains, intervertebral disc compromise, and compression fractures. Additionally, as is the case with most health care interventions, there is a certain (albeit rare) inherent risk of complications associated with chiropractic and rehabilitative procedures. These complications include but are not limited to muscle strains, dislocations, skin irritations, costovertebral strains, fractures, disc trauma, and cardiovascular accidents. I understand my doctor will not be able to anticipate all potential complications but elect to rely on his clinical expertise and judgment to determine courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntary participate in orthopedic, neurologic, and physical performance testing and physical, manipulative and exercise/rehabilitative therapies as deemed appropriate by my doctor. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Patient's Signature **Date:**

Guardian's Signature *(if required)* **Date:**

PATIENT FINANCIAL POLICY ACKNOWLEDGEMENT

Our financial policy is available posted on our website and is provided as a laminated handout as part of our new patient paperwork package. If you would like a printed copy of this policy for your records you may request one from our staff at any time.

I have completed Cutitta Chiropractic's Patient Information form to the best of my ability with accurate information, including insurance policy details. I have read Cutitta Chiropractic's Financial Policy and agree to its terms.

I request that payment of authorized benefits be made to Cutitta Chiropractic for any services provided to me or to another for whom I am guarantor or legal guardian. I understand that I must promptly notify Cutitta Chiropractic of changes to my insurance coverage or to the coverage of the person for whom I am guarantor or legal guardian. I acknowledge that I am financially responsible for the payment of deductibles, coinsurance, copayments, and any other charges not paid by my insurance plan or the insurance plan of the person for whom I am responsible, including any non-covered charges, such as missed appointment fees. I authorize the release of medical information to the insurance carrier and its agents for the purpose of determining which of these services are covered. I understand that if Cutitta Chiropractic is unable to collect my patient responsibility in a timely fashion they may share my information with credit collections agency to recover my debts.

Authorization must be signed by the patient or by an authorized person when the patient is a minor or is physically or mentally challenged.

Patient's Signature **Date:**

Guardian's Signature *(if required)* **Date:**

Our Privacy Policy is available posted on our website and is provided as a laminated handout as part of our new patient paperwork package. If you would like a printed copy of this policy for your records you may request one from our staff at any time.

By signing below I acknowledge that I have received a copy of Cutitta Chiropractic LLC's Notice of Privacy Practices

Patient's Signature **Date:**

Guardian's Signature *(if required)* **Date:**