

PATIENT INFORMATION

Date _____

Patient _____

Email Address _____

Address _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Social Security # _____ - _____ - _____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Spouse's Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you?

Spouse/Family Member _____

Friend _____

Doctor _____

Attorney _____

Other _____

PHONE NUMBERS

Home _____

Cell _____

Work _____ Ext. _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Contact Phone _____ Ext. _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Co. _____

Subscriber's Name _____

Subscriber Birthdate, if not pt. _____ SS# _____

Relationship to Patient _____

Group/ID # _____

Is patient covered by additional insurance? Yes No

Insurance Co. _____

Group/ID # _____

Subscriber's Name _____

Subscriber Birthdate, if not pt. _____ SS# _____

Relationship to Patient _____

ASSIGNMENT AND RELEASE/ AUTHORIZED SIGNATURE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Moss Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who signs below. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Are you currently out of work due to the accident? Yes No

Dates out of work _____

Attorney Name (if applicable): _____

Attorney Phone _____

Please be sure to give the receptionist a copy of your Insurance Card(s) and Drivers license.

CURRENT SYMPTOM LIST

Name: _____

Date: _____

HEAD:

- _____ Headaches
- _____ a. migraine in nature
- _____ b. back of Head
- _____ c. sinus (allergy)
- _____ d. temples
- _____ e. entire head
- Frequency _____ x's per _____
- _____ Head feels heavy
- _____ Lightheadedness
- _____ Fainting
- _____ Loss of memory
- _____ Eye Strain
- _____ Light bothers eyes
- _____ Blurred vision
- _____ Double vision
- _____ Loss of vision
- _____ Loss of balance
- _____ Dizziness
- _____ Loss of hearing
- _____ Pain in the ears
- _____ Ringing/buzzing in the ear/s
- _____ Loss of taste
- _____ Loss of smell
- _____ Sinus trouble
- _____ Jaw pain

NECK:

- _____ Neck pain and stiffness
- _____ Neck pain
- _____ Neck stiffness
- _____ Neck pain with movement
 - _____ forward
 - _____ backward
 - _____ turning to the left
 - _____ turning to the right
 - _____ bending to the left
 - _____ bending to the right
- _____ Muscle spasms in neck
- _____ Grinding sounds in the neck
- _____ Arthritis in the neck

SHOULDERS:

- _____ Pain in the joint L R
- _____ Pain across the shoulders
- _____ Pain between shoulder blades
- _____ Stiffness in shoulder L R
- _____ Tension in the shoulders
- _____ Muscle spasms L R
- _____ Unable to raise arm over head/over shoulder level

ARMS & HANDS:

- _____ Pain in the upper arm L R
- _____ Pain in the elbow L R
- _____ Tennis elbow L R
- _____ Pain in forearm L R
- _____ Pain in hands L R
- _____ Pain in fingers L R
- _____ Sensation of pins and needles in Arms L R
- _____ Sensation of pins and needles in fingers L R
- _____ Numbness in arms L R
- _____ Numbness in hands L R
- _____ Fingers go to sleep L R
- _____ Stiffness in fingers L R
- _____ Hands get cold L R
- _____ Swollen joints in fingers
- _____ Loss of grip strength L R

MID-BACK:

- _____ Mid-back pain and stiffness
- _____ Mid-back pain
- _____ Mid-back stiffness
- _____ Muscle spasms in mid-back
- _____ Pain in kidney area

CHEST:

- _____ Chest pain
- _____ Shortness of breath
- _____ Pain around the ribs
- _____ Breast pain
- _____ Irregular heartbeat

ABDOMEN:

- _____ Nervous stomach
- _____ Nausea
- _____ Gas
- _____ Constipation
- _____ Diarrhea
- _____ Hemorrhoids

Women Only:

- _____ Menstrual pain _____
- _____ Menstrual cramping
- _____ Irregular periods

Men Only:

- _____ Urinary frequency
- _____ Difficulty in starting urination
- _____ Night urination
- _____ Prostate swelling/pain

LOW BACK:

- _____ Low back pain and stiffness
- _____ Low back pain
- _____ Low back stiffness
- _____ Muscle spasms in low back

HIPS, LEGS & FEET

- _____ Pain in the buttocks L R
- _____ Pain in the hip joint L R
- _____ Pain down both leg
- _____ Pain down one leg L R
- _____ Leg cramps L R
- _____ Knee pain L R
- _____ _____ inside L R
- _____ _____ outside L R
- _____ Pins & needles in legs L R
- _____ Numbness in legs L R
- _____ Numbness in feet L R
- _____ Numbness in toes L R
- _____ Swollen ankles L R
- _____ Swollen feet L R
- _____ Feet feel cold

GENERAL

- _____ Anxiety
- _____ Nervousness
- _____ Irritable
- _____ Depression
- _____ Fatigue
- _____ Generally feel run down
- _____ Loss of weight _____ lbs
- _____ Gain weight _____ lbs
- _____ Excessive perspiration
- _____ Tremors
- _____ Other _____

Activities of Daily Living: Check all the activities that you are unable to do or have difficulty with because of this problem.

- Sitting Standing Lifting
- Moving Arms Moving legs
- Bending at waist Carrying
- Lying/sleeping Pulling
- Pushing Kneeling Twisting or turning back Twisting or turning neck
- Turning over Reaching Grooming
- Dressing Bathing Going to the bathroom Recreational activities
- Golfing Sexual relations
- Going up/down stairs Laundry Household chores/Housework Cough/sneeze Riding in car

PATIENT CONDITION

Main Complaint: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an "X" on the picture where you continue to have pain, numbness, or tingling

NECK: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness Swelling

Neck Pain is Constant Frequent Intermittent Occasional

Headaches are Constant Frequent Intermittent Occasional

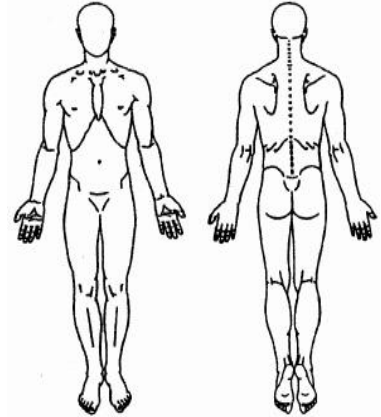
MID BACK: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness Swelling

Mid Back Pain is Constant Frequent Intermittent Occasional

LOW BACK: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Tingling Cramps Stiffness Swelling

Low back Pain is Constant Frequent Intermittent Occasional

OTHER AREA: _____ Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Pain is Constant Frequent Intermittent Occasional



On a scale from 1 – 10, where 1 feels great and 10 is the worst pain possible, please rate your pain:

1 2 3 4 5 6 7 8 9 10 Location: _____

1 2 3 4 5 6 7 8 9 10 Location: _____

1 2 3 4 5 6 7 8 9 10 Location: _____

Pain radiates into: Shoulder/Arms left right Hips/Legs left right Other: _____

CURRENT HEALTH HISTORY

What treatment have you already received for your current condition? (circle all that pertain)

Medications Surgery Physical Therapy Chiropractic Adjustments None Other _____

Are you presently taking any medication –prescription or over-the-counter? Please list them here:

Name and address of other doctor (s) who have treated you for your condition:

Has any other doctor/hospital taken any X-rays, MRI, CT Scans because of your present condition?

____ Yes ____ No

If Yes, When? _____ Date Where? _____

Were the x-rays taken while standing? ____ Yes ____ No

Have you had any laboratory work done lately? Blood Urine _____

PREGNANCY DISCLAIMER:

Women: Is there any chance that you are pregnant? ____ Yes, I am ____ months pregnant ____ No

OUR FINANCIAL POLICY

Thank you for choosing Moss Chiropractic Clinic as your healthcare provider. We are committed to your treatment being a success. Our Insurance Department along with our Patient Care Managers will work very hard to make sure your paperwork is filed accurately and promptly.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

AUTHORIZATION AND ASSIGNMENT

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however that all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempt and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Florida.
5. I further agree that this Authorization is irrevocable until all monies owed Moss Chiropractic Clinic are paid in full.

Patient signature or authorized person acting on patient's behalf

RECORDS RELEASE

I hereby authorize you to release to _____
Any information including the diagnosis and records of any examination or treatment rendered to me during the period between _____ and _____.

(We may release all if dates left blank)

Patient signature or authorized person acting on patient's behalf

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authorization for these procedure to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. **I am the responsible party for payment of any treatment received or incurred on this account.** This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardians Signature: X _____ **Date:** _____

Witness' Signature: X _____ **Date:** _____

Medical Information Release

Would you like us to keep your primary care physician/family doctor apprised of your condition? This is good idea because with proper communication between each office, we can ensure that you are getting the highest quality of care possible.

Please provide your Primary MD's information below:

Name: _____

Clinic Name: _____

Address: _____

Phone: _____

Fax: _____

I, _____, give permission to Dr. Moss, his staff, associates, and employees of Moss Chiropractic Clinic to share private and medical information with my medical doctor, _____ as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Moss and his staff.

Signature: _____ Date: _____

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Date of Birth: _____

Moss Chiropractic Clinic 1377 Deltona Blvd. Spring Hill, FL 34606

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