New Patient Information Form

PLEASE PRINT

GENERAL INFORMATION

Patient LAST name: _____ FIRST name: _____

Address: _____ Care of: _____

City: _____ State: _____ Zip: _____ Phone (H): _____

DL #: _____ No. Children: _____ Phone (C): _____

Out of State Address: _____ Phone: _____

Spouse's Name: _____ Spouse's Employer: _____ Native Language: _____

Email Address: _____

Sex: M / F Married / Single / Widowed / Divorced DOB ____/____/____ SS# _____

Employer's Name: _____ **EMPLOYED**: Full Time / Part Time / Retired / Unemployed

Employer's Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Occupation: _____ **STUDENT:** Full Time / Part Time / Non-Student

INSURANCE INFORMATION – Commercial Insurance and Medicare **Only**

PRIMARY Insurance Company

_____

Type Group Private

Membership/Cert #: _____

Policy Group #: _____

Complete only if Patient is **NOT** the Insured

Insured's Information:
Insured's Name: _____
M / F Married Single Widowed Divorced
Patient Relation to Insured: _____
Insured's DOB: ____ / _____ / _____
Insured's Employer: _____

SECONDARY Insurance Company

_____

Type Group Private

Membership/Cert #: _____

Policy Group #: _____

Complete only if Patient is **NOT** the Insured

Insured's Information:
Insured's Name: _____
M / F Married Single Widowed Divorced
Patient Relation to Insured: _____
Insured's DOB: ____ / _____ / _____
Insured's Employer: _____

AUTOMOBILE ACCIDENT/ WORKER'S COMPENSATION

Insurance Company: _____ Claim #: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Injury: ____/____/____

Attorney's Name: _____ Phone Number: _____

Address: _____ Contact Name: _____

Release and Assignment

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patients Signature: _____ Date: _____

Jupiter West Medical Center
2632 West Indiantown Road
Jupiter, FL 33458
Phone: 561-744-7373 Fax: 561-743-1192

ASSIGNMENT OF BENEFITS

I, the undersigned patient, hereby assign my Personal Injury Protection insurance benefits under my policy of automobile insurance or all other applicable Private policies benefits under my medical insurance, for all causes of actions to **JUPITER WEST MEDICAL CENTER** its subsidiaries and its agents, including but not limited to **JUPITER WEST MEDICAL CENTER** for services rendered to the undersigned patient in accordance with Florida Statue 627.736(5), that would otherwise be payable to me for services rendered.

I fully understand that by the execution of this assignment of benefits, that I also grant **JUPITER WEST MEDICAL CENTER** ,its subsidiaries and its agents including but not limited to **JUPITER WEST MEDICAL CENTER** full power of attorney and authority to act in or on my behalf insofar as the endorsing and cashing of checks as well as the execution of any other documents that may be related to this matter or claim. I agree to be fully responsible for the services provided regardless of settlement, judgment or verdict. I further direct my Private insurance carrier to provide any medical provider with an updated copy of the PIP Payment Log. A photocopy of this document shall be as binding as the original signature page.

PATIENT CONSENT FORM

I hereby indicate my wish to be a participant in the rehabilitation program offered by:

_____

I understand that the purpose of this program is to enhance my recovery from an injury or illness.
I further understand that there exists the possibility that certain changes may occur during my treatment.

I have been informed of the procedures and methods of treatment that will be administered to my _____, and I fully understand what is required for me as a patient.

I verify that my participation is fully voluntary, no coercion of any sort has been used to obtain my participation, and I may withdraw from treatment at any time.

I understand that the facility administrator maintains an open door policy and encourages patients to participate or any reason.

PATIENTS/INSURED SIGNATURE_____

DATE_____

FINANCIAL POLICY AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless our staff has approved payment arrangements in advance. We accept CASH, CHECK, MASTER, DISCOVER, AMERICAN EXPRESS, or VISA CARDS. We will be happy to help you process your insurance claim-form for your reimbursement.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of **1.5 %** per month. We will gladly discuss your proposed treatment ans answer any questions relating to your insurance.

You must realize, however that:

1- You insurance is a contract between you, your employer and the insurance company. We are not a party to contract.

2- Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (50% or 80%) of "U.C.R."
"U.C.R." is defined as usual, customary and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical providers, our relationship is with you and not with your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage PLEASE do not hesitate to ask us. We are here to help you.

PATIENTS/INSURED SIGNATURE_____

INSURANCE COMPANY_____

DATE_____

DATE OF ACCIDENT_____
(If applicable)

PRIVACY PRACTICES ACKNOWLEDGMENT

Posted on Lobby Wall

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy practices and I have been provided an opportunity to review it.

NAME _____BIRTHDATE _____

SIGNATURE _____

DATE _____

WAIVER

I acknowledge that I was given the opportunity to accept the Notice of Privacy Practices and have chosen not to receive that Notice or have it explained to me.

NAME_____ BIRTHDATE_____

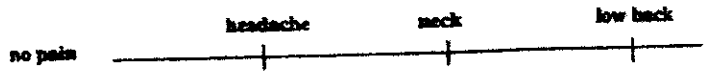
SIGNATURE _____

DATE _____

QUADRUPLE VISUAL ANALOGUE SCALE

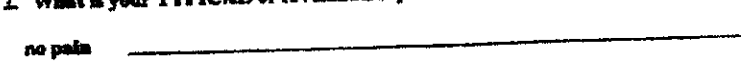
INSTRUCTIONS: Please put a mark on the line that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

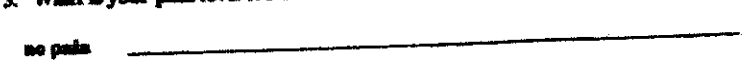


1. What is your pain RIGHT NOW?

2. What is your TYPICAL or AVERAGE pain?



3. What is your pain level AT ITS BEST?

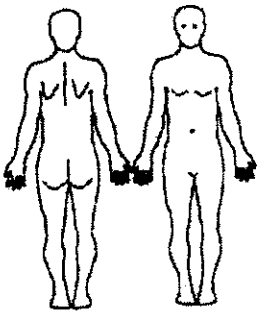


What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST?

What percentage of your awake hours is your pain at its worst? _____%

Mark the diagram as follows:
A - Ache
B - Burning
N - Numbness
P - Pins & Needles
S - Stabbing
O - Other - Describe



NAME _____ **AGE**_____ **DATE**_____ **SCORE**_____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

Medical History Questionnaire
(Confidential Information)

Patient's Name: _____ Date: _____

Reason for Visit: _____

MEDICAL HISOTRY: Please circle the following:

High Blood Pressure	Y / N	Skin Disease	Y / N
Bleeding Disorder	Y / N	Thyroid Disease	Y / N
Anemia	Y / N	Lung Disease	Y / N
Liver Disease	Y / N	Tuberculosis	Y / N
Heart Disease	Y / N	Shortness of Breath	Y / N
Psychiatric Illness	Y / N	Hepatitis	Y / N
HIV	Y / N	Diabetes	Y / N

Please list any other medical history the doctor should be aware of:

_____

Please list any prior hospitalizations below (ie, accidents, etc)

_____

_____

FAMILY HISTORY: Please give the age of living or age and cause of death.

Father: _____ Mother: _____

Siblings: _____ Children: _____

MEDICATIONS: Please list medications you currently take, **including** appetite suppressants, vitamins, herbal supplements., or any homeopathic medication:

_____

_____

Do you take any Aspirin or any Aspirin- containing compound? _____ If "Yes", for what reason?

_____

Do you have any ALLERGIES and/or SENSITIVITIES? (Please indicate which, if any, are present)?

Penicillin	Y / N	Aspirin	Y / N
Sulfa	Y / N	Xylocaine	Y / N
Any other Antibiotics	Y / N	Adhesive Tape	Y / N
Codeine	Y / N	Tetanus Toxic	Y / N

Any other _____

SOCIAL HISTORY:

Cigarette Smoking Y / N How long since last use? _____

Alcohol Use Y / N Drugs: _____

Caffeine: None:_____ Daily: _____ How much? _____

Do you take Vitamin E? Y / N If "Yes," how much? _____

SURGICAL HISTORY:

Please list all previous surgeries/operations, as well as cosmetic:

_____ Date:_____

_____ Date:_____

_____ Date:_____

Please list any complications or problems you experienced during or following the above procedures:

_____

Do you wear corrective eye glasses or contacts? _____

Date of last opthalmology (eye) check up? _____

Have you recently been under the care of a physician for any reason? Y / N
If Yes, please explain

_____

Family Physician: _____ Date of last check up: _____

Address: _____ Phone: _____

Note: if you are scheduled for surgery at any time, please be advised that you cannot take aspirin or aspirin-containing products for a period of two weeks prior to your surgery. Evidence suggests that even small amounts of aspirin or other anti-inflammatory products can create bleeding problems in the apparently healthy adult. Acetaminophen, such as Tylenol, may be used as a substitute for aspirin.

Papa Chiropractic and Physical Therapy
2632 W Indiantown Road
Jupiter, FL 33458
(561) 744-7373
(561) 743-1192 Fax

RELEASE OF RECORDS

Date: _____

To: _____
(Doctor or Hospital)

Address: _____

_____

I hereby authorize and request you to release my complete medical records, concerning my illness and/or treatment during the period of: _____ to _____.

To: Papa Chiropractic and Physical Therapy
2632 W Indiantown Road
Jupiter, FL 33458
(561) 744-7373
(561) 743-1192 Fax

Name: _____

DOB: _____

Date: _____

Signed: _____
(Signature of patient/guardian, if patient is a minor.)

Papa Chiropractic and Physical Therapy
2632 W Indiantown Road
Jupiter, FL 33458
(561) 744-7373

X-RAY CONSENT FORM & PREGNANCY RELEASE IF APPLICABLE

Patient Name: _____

Patient Date of Birth: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

FEMALE ONLY 1-4

1. Are you pregnant or any chance you may be: YES / NO
2. Date of the start of your last period: _____
3. Are you on any type of Birth Control? YES / NO
4. Are you trying to get pregnant? : YES / NO

Your signature indicates that you have read, understood and answered all of the above and accept all responsibility associated with exposure to yourself or your unborn child and have accurately answered the above statements.

Signature: _____ Date: _____

Witness: _____ Date: _____