INSURANCE QUESTIONNAIRE

- PLEASE ANSWER ALL QUESTIONS COMPLETELY-

PATIENT INFORMATION: **DATE:** _____

Name: _____ **SS #:** _____

Sex: Male Female **E-mail address:** _____

Marital Status: S M D W **Primary Language:** _____

Race: Caucasian Black Asian Other **Ethnicity:** Hispanic Non-Hispanic

Birth date: _____ -_____ -_____ **Age:** _____ **Are you a minor?** _____

Address: _____
Street Address Town State Zip code

Home Phone: ( ) _____ **Cell Phone:** ( ) _____
please indicate which number is best to reach you at

EMPLOYMENT INFORMATION:

Employer /Business Name: _____

Phone #: ( ) _____ **EXT:** _____

Address: _____

Job Title: _____

INSURANCE INFORMATION:

Insurance Company: _____ **ID Number:** _____

Group Number: _____ **Name of the policyholder:** _____

Relationship to the patient: Self Spouse Child Other

Address of policyholder if different from patient:

_____

DOB of policyholder: _____

I clearly understand and agree that all health insurance policies are an agreement between me and my insurance carrier. I clearly understand and agree that all services rendered to me are charged directly to my carrier and that I may be responsible for payment if services are not covered.

Patient Signature: _____ Date: _____

How were you referred to our office? : _____

PAIN DRAWING

Name: _____ Todays Date: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache > > > >
> > > >

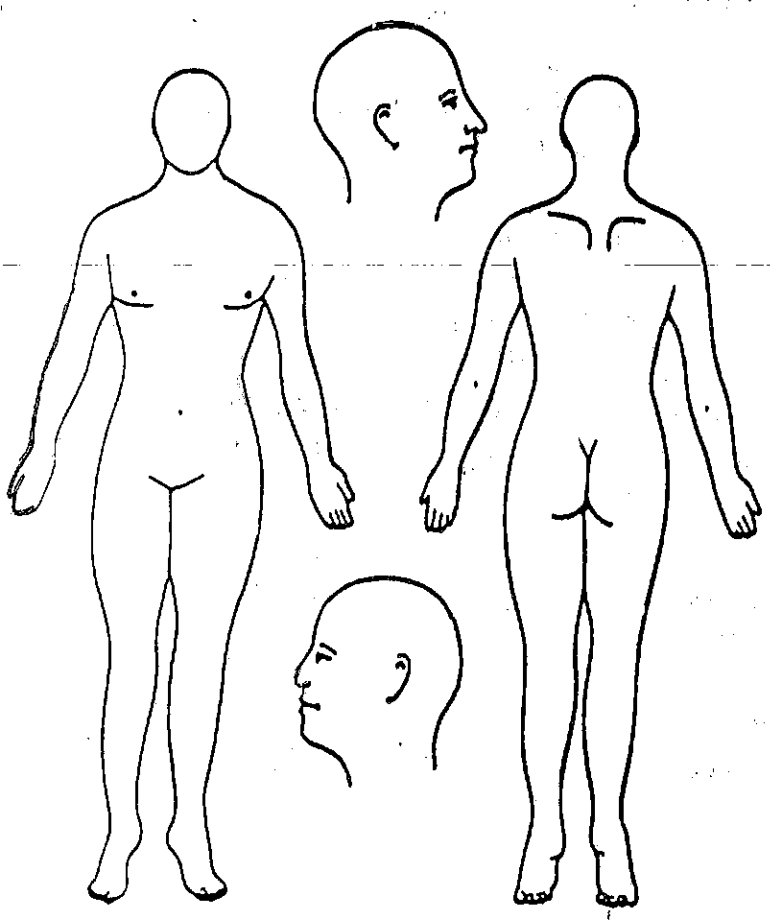
Numbness - - - -
- - - -

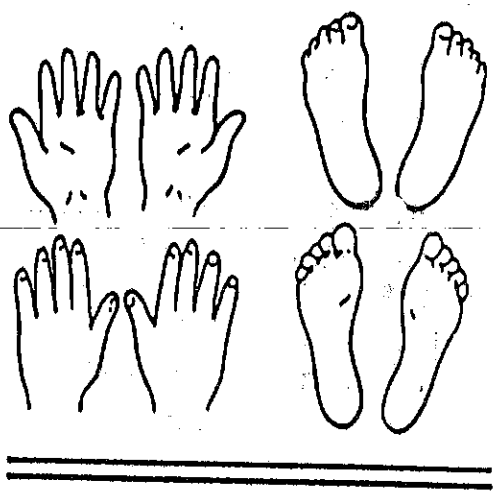
Pins and Needles o o o o
o o o o

Burning x x x x
x x x x

Stabbing / / / /
/ / / /

Throbbing ~ ~ ~ ~
~ ~ ~ ~





SEVERITY OF PAIN

List region of pain and circle severity number. [1 = least, 10 = greatest]

ex. Neck
1 2 3 (4) 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

5. _____
1 2 3 4 5 6 7 8 9 10

HEALTH QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY:

MUSCULO SKELETAL SYSTEM

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Rupture
___ Broken bones

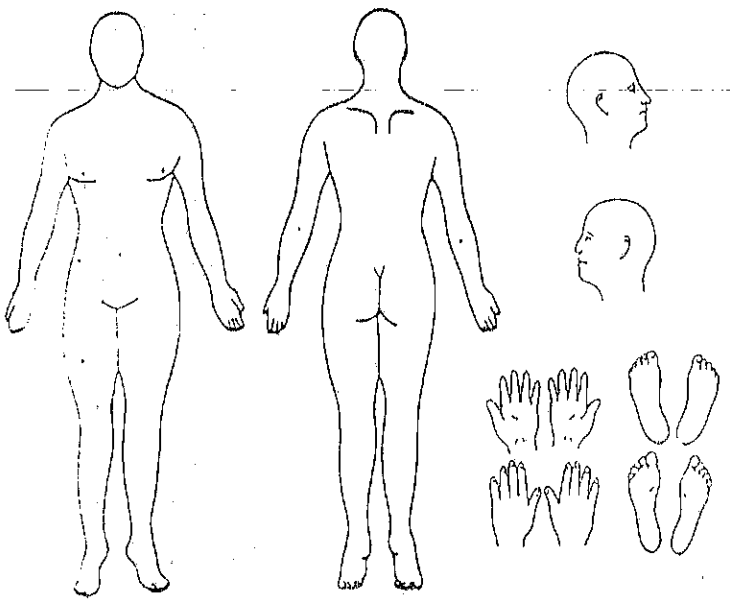
GENITO-URINARY SYSTEM

___ Bladder trouble
___ Excessive urination
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Are you pregnant?
___ Yes ___ No



GASTRO-INTESTINAL SYSTEM

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIO VASCULAR RESPIRATORY SYSTEM

___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYES, EAR, NOSE AND THROAT

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficulty breathing thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

_____
Patient's Signature

**********DO NOT WRITE BELOW THIS LINE**********

Patient Accepted? Yes No Doctor's Signature_____

South Shore Chiropractic, P.C.

700 Horseblock Rd.
Farmingville, NY 11738
Telephone: (631) 732 – 1386
Fax: (631) 732 – 1544

450 William Floyd Parkway
Shirley, NY 11967
Telephone: (631) 395 – 8520
Fax: (631) 395 – 8521

sschiropractic@optonline.net

I _____, declare that I am receiving treatment for a condition **unrelated** to a workers' compensation or automobile accident injury. There is no other carrier responsible for the claims being submitted. Please remit payment for these services directly to:
Michael J. Campo, DC at South Shore Chiropractic, PC

1. Date when condition started:_____
2. Address/ location where condition started:
   _____
3. Cause of injury/ Condition (briefly describe):
   _____
   _____
4. Condition was **not** related to a motor vehicle accident Initial:_____
5. Condition was **not** related to patients employment Initial:_____

I hereby certify that all of the above responses are true to the best of my knowledge.

Patient's Signature:_____ Date:_____

Witness: _____

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Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who nor or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. _____

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dr. Michael J. Campo Dr. Jayesh Patel Dr. Marc Avvento

_____ _____

Patient Signature (or patient representative) Date

(indicate relationship if signing for patient) _____

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Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

South Shore Chiropractic, P.C.
700 Horseblock Rd.
Farmingville, NY 11738

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

South Shore Chiropractic, P.C.
700 Horseblock Rd.
Farmingville, NY 11738

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at South Shore Chiropractic, P.C. this _____ (Date) day of _____ (Month), 20____

_____ Signature of Policyholder

_____ Witness

_____ Signature of Claimant, if other than Policyholder