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? : _____

36530

DC Patient Intake Form
(version 1.1)
www.palladianhealth.com/members

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Last name | **First name**

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

O Neck	O Shoulder	O Hip	O Headache
O Upper/ mid back	O Elbow	O Knee	O Other
O Lower back	O Wrist	O Ankle	
	O Hand	O Foot	

2. When did this problem first begin?

O Less than 1 month ago O 1-3 months ago O 4-6 months ago O 7-12 months ago O More than 1 year ago

	Has this problem...	No	Yes
3.	... resulted from a work injury (i.e. workers' compensation insurance claim)?	O	O
4.	... resulted from a motor vehicle accident (i.e. no fault insurance claim)?	O	O
5.	... recently been evaluated by a medical doctor?	O	O
	Since this problem began, have you noticed...	**No**	**Yes**
6.	... so much weakness in both your arms that you are unable to lift them?	O	O
7.	... so much weakness in both your legs that you are unable to walk without help?	O	O
8.	... difficulty controlling your bowel or bladder, or have you been unable to urinate?	O	O
9.	... pain in your chest, shortness of breath, or coughing up blood?	O	O
10.	... that one leg felt more warm, more swollen, more red, or more tender than the other?	O	O
	Have you recently...	**No**	**Yes**
11.	... had blurred vision, double vision, dizziness, or fainting?	O	O
12.	... had any type of infection, fever, or chills?	O	O
13.	... had any type of surgery, surgical procedure, or medical procedure?	O	O
14.	... lost a lot of weight without really trying to (i.e. without being on a diet)?	O	O
15.	... had any type of accident, fall, or trauma?	O	O
	Have you ever...	**No**	**Yes**
16.	... been diagnosed with cancer?	O	O
17.	... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?	O	O
18.	... been diagnosed with a weakened immune system?	O	O
19.	... used any injected drugs (i.e. non-prescription drugs)?	O	O
20.	... used steroids such as prednisone for more than 4 weeks?	O	O
	Is this problem something that ...	**No**	**Yes**
21.	... you've had before?	O	O
22.	... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise?	O	O
23.	... generally gets better (i.e. less severe or frequent) with rest?	O	O
24.	... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?	O	O
25.	... is also being treated by a health professional other than a chiropractor?	O	O

Service Date: M M / D D / Y Y Y Y

36530

45804

DC Patient Outcomes Form
(version 1.1)
www.palladianhealth.com/members

Palladian

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Last Name | **First Name**

1. In general, would you say your health is	Excellent	Very good	Good	Fair	Poor
	O	O	O	O	O

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	Yes, limited a lot	Yes, limited a little	No, not limited at all
	O	O	O
3. Climbing several flights of stairs	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. Accomplished less than you would like	O	O	O	O	O
5. Were limited in the kind of work or other activities	O	O	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6. Accomplished less than you would like	O	O	O	O	O
7. Did work or other activities less carefully than usual	O	O	O	O	O

8. During the <u>past week</u>, how much did pain interfere with your normal work (including work outside the home and housework)?	Not at all	A little bit	Moderately	Quite a bit	Extremely
	O	O	O	O	O

These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>past week</u>...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	O	O	O	O	O
10. Did you have a lot of energy?	O	O	O	O	O
11. Have you felt downhearted and depressed?	O	O	O	O	O

12. During the <u>past week</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	O	O	O	O	O

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		O	O	O	O	O	O	O	O	O	O	O	
14. On average		O	O	O	O	O	O	O	O	O	O	O	
15. At its best		O	O	O	O	O	O	O	O	O	O	O	
16. At its worst		O	O	O	O	O	O	O	O	O	O	O	

Service Date: M M / D D / Y Y Y Y

45804

South Shore Chiropractic, P.C.

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

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

Fax: (631) 732 – 1544
sschiropractic@optonline.net

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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Shirley, NY 11967
Telephone: (631) 395 – 8520
Fax: (631) 395 – 8521

sschiropractic@optonline.net

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