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? : ______________________________

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

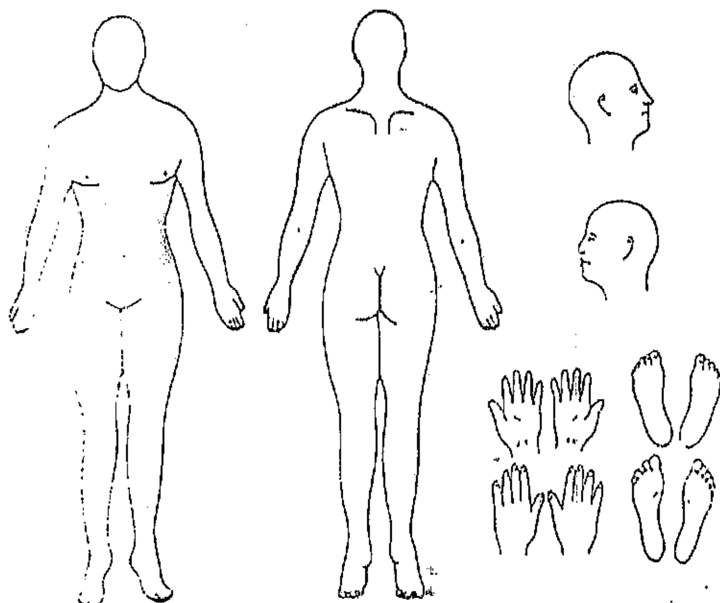
GENITO-URINARY SYSTEM

___ 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

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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Medicare Authorization of Benefits

DATE: ________________

Name of Patient: ______________________________________

Medicare Number: ________________________

I request that payment of authorized Medicare benefits be made on my behalf to South Shore Chiropractic, PC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and its agents any information needed to determine these benefits or the benefits payable for related service.

Dated at South Shore Chiropractic this ___________ day of ____________, 20_____

Patient Signature ____

Witness _____________________________________