Thomas Chiropractic Center/Plantation Health and Wellness, LLC

7330 NW 5th St. Plantation, FL 33317

Patient Name_____ Date: _____ Email: _____

DOB_____ □ Male □ Female Home phone_____ Cell Phone _____

SS #/SIN_____ Check appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated

Have you had previous Chiropractic care? YES NO Was it a positive experience? YES NO

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Primary Physician Name:_____Physician Phone #:_____

May we contact your primary physician regarding your treatment in our office: □ Yes □ No

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence. Initial Here:_____

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____ Date of Birth:_____Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Thomas Chiropractic Center/Plantation Health and Wellness, LLC as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name)

Health History

Patient Name: _____DOB: _____Date:_____

History of Present illness: Chief Complaint:_____
(What brings you to the office today?)

Location of pain: _____
(Example: Right/Left, Neck Pain, Lower Back Pain…)

Quality: _____
(Example: Achy, Sharp, Stabbing, Throbbing, Burning)

Severity: _____
(Pain/problem on a scale of 1-10 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does it occur at a specific time? Morning/Evening/All Day)

Onset: _____
(When and How did it start?)

Radiating Signs/Symptoms _____
_____
(Does it radiate? Where?)

Modifying Factors_____
_____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles……	NO YES	Anemia……..NO	YES	Back Trouble……..NO	YES	Hepatitis……NO	YES
Mumps…….	NO YES	Bladder Infection…….NO	YES	High Blood Pressure……NO	YES	Ulcer……NO	YES
Chicken Pox……	NO YES	Epilepsy……NO	YES	Low Blood Pressure…….NO	YES	Kidney Disease…NO	YES
Whooping Cough…	NO YES	Migraine Headaches. NO	YES	Hemorrhoids……..NO	YES	Thyroid Disease….NO	YES
Scarlet Fever…….	NO YES	Tuberculosis……..NO	YES	Bleeding Tendency…….NO	YES	Polio……..NO	YES
Diphtheria……	NO YES	Diabetes……..NO	YES	Asthma……..NO	YES	Small pox……	NO YES
Hives of Eczema…..NO	YES	Pneumonia……	NO YES	AIDS & HIV……NO	YES	Arthritis……	NO YES
Rheumatic Fever…	NO YES	Glaucoma……NO	YES	Infectious Mono……NO	YES	Hernia……NO	YES
Bronchitis……..NO	YES	Venereal Disease…….	NO YES	Blood or Plasma……..	NO YES		
Mitral Valve Prolapses….NO	YES			Transfusion……..NO	YES	Stroke……NO	YES

Date of Last Chest X-Ray_____ Cancer……NO YES (Please List): _____
Any Other Disease….NO YES (Please List): _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Car Accidents/Falls/Fractures	When?	
_____	_____	_____
_____	_____	_____

Medication: (include nonprescription)
_____
_____

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			

Excessive Exposure At home or at work to: Fumes: ___ Dust: ____ Solvents: _____ Airborne Particles: _____Noise: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

Name:_____ DOB _____ Date:_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**		**Neurological**		**General**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5			Diarrhea	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5			Feeling foggy	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5			Forgetfulness	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5				
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5				
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5				
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5				
Wheezing	1 2 3 4 5						

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date