Healing Hands Chiropractic Registration & History

Patient Information

Date _____

First Name _____ Last Name _____ M.I. _____

Birth Date _____

Address _____

City _____ State _____ Zip Code _____

Occupation _____ Employer Phone Number _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Minor

Who may we thank for referring you? _____

Contact Information

E-mail _____

Home Phone Number _____ Cell Phone Number _____

In Case of Emergency Contact Name _____ Phone Number _____

Accident Information

Is this condition due to an accident? ☐ Yes ☐ No Date of Accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

Have you reported this accident? ☐ Auto Insurance ☐ Employer ☐ Worker's Comp. ☐ Attorney ☐ Other

Attorney Name (if applicable) _____

Attorney Phone Number _____

Assignment & Release

I certify that I, and/or my dependent(s) have insurance coverage with _____ (name of insurance company) and assign directly to Dr. Nicholas Venturino all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether, or not, paid by my insurance. I authorize the use of my signature on all insurance submissions.

Dr. Venturino may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____ _____

(Patient's Signature) (Patient's Printed Name) (Date)

Patient Condition

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting worse? ☐ Yes ☐ No ☐ Unknown

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last

Physical Exam_____ Spinal X-Ray_____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRT, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS / HIV	☐ Y	☐ N	Chicken Pox	☐ Y	☐ N	Liver Disease	☐ Y	☐ N	Rheumatoid Arthritis	☐ Y	☐ N
Alcoholism	☐ Y	☐ N	Diabetes	☐ Y	☐ N	Measles	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Allergy shots	☐ Y	☐ N	Emphysema	☐ Y	☐ N	Migraine Headache	☐ Y	☐ N	Scarlet Fever	☐ Y	☐ N
Anemia	☐ Y	☐ N	Epilepsy	☐ Y	☐ N	Miscarriage	☐ Y	☐ N	Stroke	☐ Y	☐ N
Anorexia	☐ Y	☐ N	Fractures	☐ Y	☐ N	Mononucleosis	☐ Y	☐ N	Suicide Attempt	☐ Y	☐ N
Appendicitis	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Multiple Sclerosis	☐ Y	☐ N	Thyroid Problem	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Goiter	☐ Y	☐ N	Osteoporosis	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Asthma	☐ Y	☐ N	Gonorrhea	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Bleeding Disorder	☐ Y	☐ N	Gout	☐ Y	☐ N	Parkinson's	☐ Y	☐ N	Tumors, Growths	☐ Y	☐ N
Breast Lump	☐ Y	☐ N	Heart Disease	☐ Y	☐ N	Pinched Nerve	☐ Y	☐ N	Typhoid Fever	☐ Y	☐ N
Bronchitis	☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Pneumonia	☐ Y	☐ N	Ulcers	☐ Y	☐ N
Bulimia	☐ Y	☐ N	Hernia	☐ Y	☐ N	Polio	☐ Y	☐ N	Vaginal Infection	☐ Y	☐ N
Cancer	☐ Y	☐ N	Herniated Disk	☐ Y	☐ N	Prosthesis	☐ Y	☐ N	Venereal Disease	☐ Y	☐ N
Cataracts	☐ Y	☐ N	Herpes	☐ Y	☐ N	Psychiatric Care	☐ Y	☐ N	Whooping Cough	☐ Y	☐ N
Chemical Dependency	☐ Y	☐ N	High Cholesterol	☐ Y	☐ N						
			Kidney Disease	☐ Y	☐ N				Other _____		

EXERCISE

☐ None ☐ Moderate ☐ Daily ☐ Heavy

Are you Pregnant? ☐ Yes ☐ No Due Date _____

Previous Hospitalizations/Surgeries/Serious Illness:_____

_____

Please list any and all allergies:_____.

Please list any medications that you take:_____.

Patient Social History: (please circle)

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously, but quit: (date)_____ Current Packs/day:_____

Use of drugs: Never Type/Frequency:_____

Family Medical History:

	Age	Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
siblings'	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

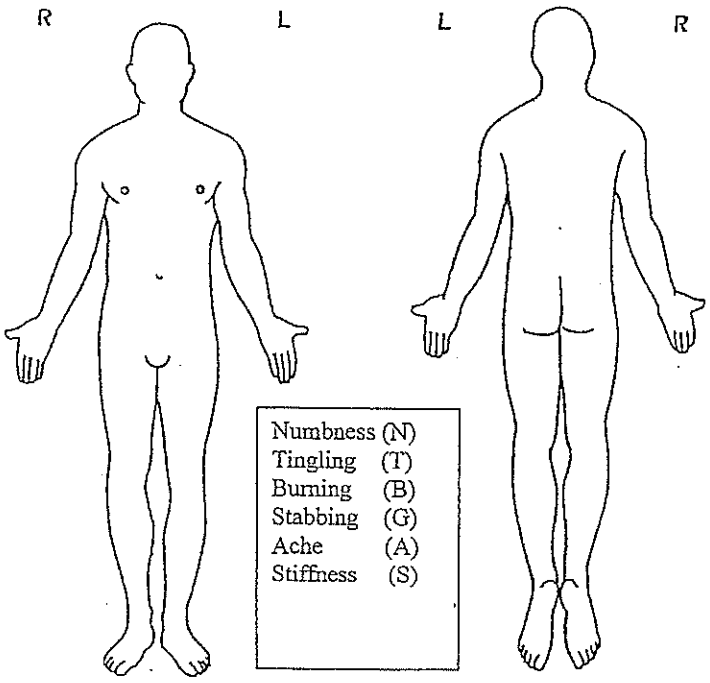
Doctors Signature:_____ **Date:**_____

Healing Hands Chiropractic P.A.

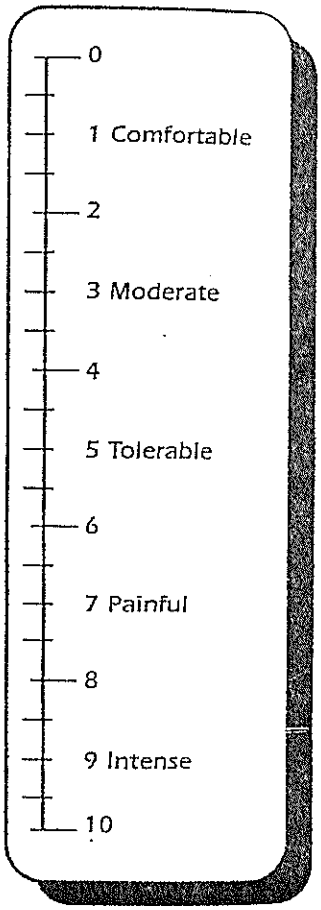
Patient Name: _____ **Date:** _____

PAIN QUESTIONNAIRE

Using the appropriate symbols, please indicate on the figure the location and sensation of your Pain



My pain level today is:
(Please mark an "X")



Postures and activities that increase pain are: _____

_____

_____

Postures and activities that decrease pain are: _____

_____

_____

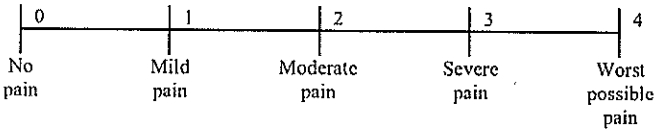
Time of day may pain is most intense: _____

Functional Rating Index

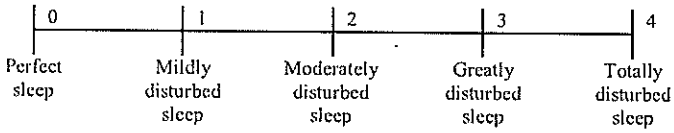
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

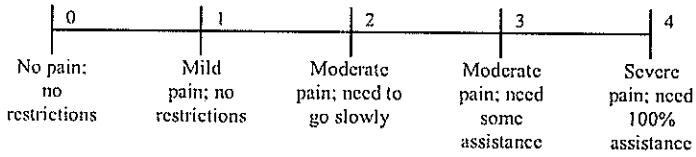
1. Pain Intensity



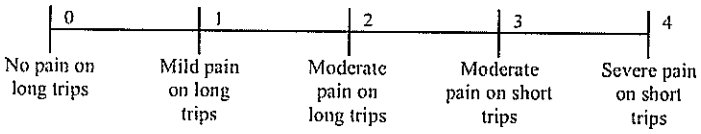
2. Sleeping



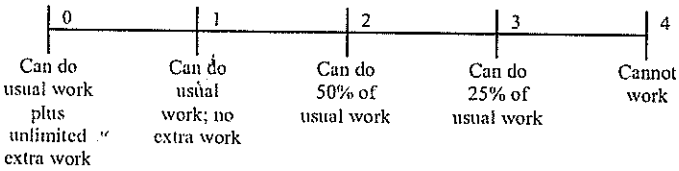
3. Personal Care (washing, dressing, etc.)



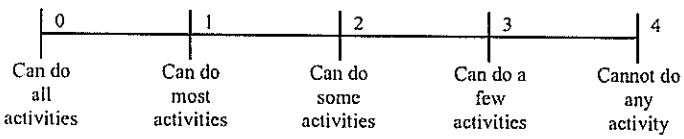
4. Travelling (driving, etc.)



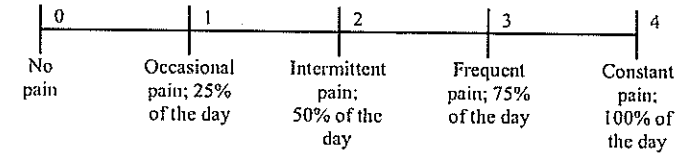
5. Work



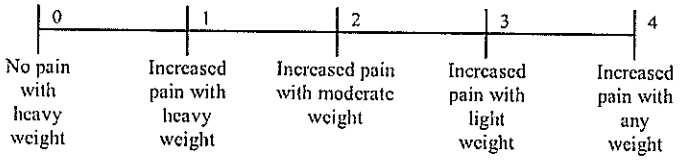
6. Recreation



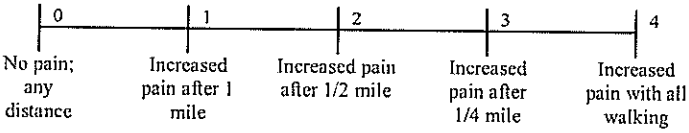
7. Frequency of Pain



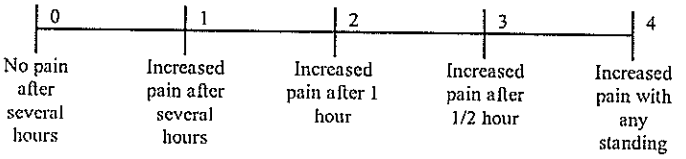
8. Lifting



9. Walking



10. Standing



_____

Patient's Signature

_____

Date

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____

Healing Hands Chiropractic P.A.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Name: _____ **Date:** _____

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move you joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you feel the movement of the joint. Various ancillary procedures, such as hot or cold packs, neuro-muscular massage, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as " rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in a million to one in twenty million, and can be even further reduced by screening by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other Treatment Options which could be considered may include the Following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multiple of undesirable side effects and patient dependence is a significant number of cases.
- Hospitalization in conjunction with medical care adds the risks of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds he risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have the following unusual risks of my case explained to me:

_____

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits or undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____

Printed Name **Signature**

Healing Hands Chiropractic P.A.

GENERAL PATIENT RESPONSIBILTIES

I understand that I remain personally responsible for the total amount due Assignees for their services as insurance coverage may only pay a certain percentage of the bill; as, I may have an insurance deductible or my insurance benefits may exhaust or otherwise be limited. I further understand and agree that the Lien and Authorization does not require Assignees to await payment and the may demand payment from me immediately upon rendering services at their option, Although the assignees agree to first demand immediate payment from the insurance company as their first means to pursuing payment for the services rendered. Also, I understand that if this account is assigned to an attorney for collections and/or suit, the assignee shall be entitled to reasonable attorney's fees and costs for collection. I also understand that if any bad check is written, I agree to pay for these added costs.

_____ _____

Patient's Signature **Date**

_____ _____

Patient's Printed Name **Date**

_____ _____

Witness **Date**

PREGNACY RELEASE FOR X-RAYS

I, _____ do hereby state to the best of my knowledge that I am not pregnant and give full permission to Healing Hands Chiropractic P.A., their associates or assistants to x-ray me. My last cycle began on _____.

_____ _____

Patient's Signature **Date**

_____ _____

Witness **Date**

MINOR CONSENT FORM

Patient Name: _____ **Date:** _____

I hereby request an authorize Healing Hands Chiropractic P.A., to render treatment to my minor son/daughter _____. This authorization is extended to all affiliated doctors and staff members and is intended for the performance of diagnosis tests, chiropractic adjustments, radiographic, examination (at the doctor's discretion), as well as other treatment necessary or the patient's care.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable), Under the terms and conditions of my divorce, separation or legal authorization, the consent of spouse, former spouse or other parent is not required. If my authority to select and authorize care to my son/daughter should be revoke or modify in any way, I will notify this office immediately.

_____ _____

Signature of Parent or Legal Guardian **Print Name**

_____ _____

Signature of Parent or Legal Guardian **Print Name**

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize _____ (name of practice) to release a copy of my patient records or x-rays containing protected health information to. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

_____ _____

Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

_____ Date Signed

Specific description of information to be disclosed:

Patient Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date of birth: _____

Medical Doctor's Information

Name of doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____

Healing Hands Chiropractic

Healing Hands Chiropractic P.A.

14491 University Cove PL., Tampa, Florida 33613 ♦ Telephone: (813) 977-2383 ♦ Fax: (813)977-2585

Office Policy

Patient – Doctor Agreement

The purpose of these agreements is to allow us to more completely serve you and to get the best result in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

New Injuries

In the event you sustain a new injury, please let the front desk know as soon as possible. There may be additional paper work to be filled out.

Appointments

After your visit, please stop at the front desk to make or confirm your next appointment.

Stress and Wellness Awareness

We will have a consultation to explain how the body functions, how chiropractic works and most importantly, how you can expedite the healing process. Family and friends are encouraged to accompany you at this time. There is no charge for this consultation.

Payment of Bills

We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our financial manager immediately so that new agreements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.

Rescheduling Appointments

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day. If the same day is not possible, be sure to make up a missed appointment within one week.

Progress Evaluations and Re-examinations

Progress evaluations and re-examinations will be done periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments.

Upsets

We are here to serve you. Please speak with the staff or doctor about anything that could upset you (i.e. long waits, staff sensitivity, and treatment confusion). We see your comments as helping us to help you and others.