Long Island Chiropractic & Wellness Center 2296 Hempstead Turnpike East Meadow, NY 11554

**PATIENT REGISTRATION:**  Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City,State,Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_ Sex ( ) Male ( ) Female

Married ( ) Yes ( ) No Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Single ( ) Yes ( ) No Other ( ) Yes ( ) No

Are you currently Working ( ) Yes ( ) No Retired ( ) Yes ( ) No Last Date worked?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

Primary Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF PATIENT IS A MINOR OR YOU ARE COVERED UNDER ANOTHER PERSON’S INSURANCE:

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\

Chief Complaint: What is a reason for this visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Last Name First Name Date

Did your bring films/Discs? X-Ray Y N MRI Y N CD/DVD Y N

Location: What is the location of your injury? *Check all that apply*

Spine/Back Neck R Shoulder L Shoulder R Arm L Arm Low back Hips L Leg R Leg

Other area\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State of NY – Worker’s Compensation:** If this injury was **WORK RELATED,** Please answer all of the questions below

**Check the ONE box which best describes how your problem started and answer the questions below.**

No Injury or Injury was Gradual Sudden

INJURY AT WORK From a lift twist fall bend pull Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time \_\_\_\_\_\_\_\_\_Where\_\_\_\_\_\_\_\_\_\_\_\_

**Have you missed time from work?** Y N If yes, how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days/weeks/months/years

**When is your last date worked?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are NOT working is your goal to return to work?** Y N

**Current work status?** Regular Light Duty Not working due to this injury Disabled Retired Student

**Are you currently receiving or plan to apply for:** Disability: Y N Worker’s Comp: Y N Unemployment: Y N

**Was your injury reported to your employer?**  Y N If so, Who did you report it to?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where you hospitalized for this injury?** Y N **What is your Job Title/Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On date of injury what were your work activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Please write specific details of your problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated by another physician for this condition/injury? Y N If yes? Dr\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What tests/scans have you had for this problem X-rays MRI CT Scan Bone Scan Nerve Test (EMG

If yes, what location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dominant hand: L R Ambidextrous (both)

If this injury was due to a MOTOR VEHICLE ACCIDENT. Please answer the questions below

Were you wearing a seat belt at the time of the accident? Y N Airbag deploy Y N

Your car: Hit another car Was hit in the Right Left Rear Front

Type of Accident Head on Collision Broad side collision Front impact T Collision You were pedestrian

Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If applicable what Hospital did you go to?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of pain do you have?**

Burning Dull/Aching Radiating Sharp Tightness Tingling Tightness

**What is your level of pain when active?** (1-10, 1 being the least) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your level of pain at rest?** (1-10, 1 being the least) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Date

**Duration: How long have you had your pain?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Days/months/years

**Have you had a problem like this before?** Y N Date original problem started:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When do you have the worst pain**? Morning Afternoon Night with activity

**Does your pain affect your ability to sleep?** Y N

**Does your pain get better with** (Please circle) Warmth or Cold **Does it get worse with:** Warmth/Cold/Dampness

**What makes your symptoms/pain worse?** Stretching Sitting Standing Twisting Walking Bending Squatting

Kneeling Warmth Cold Lifting Exercise Stairs Lying in bed Coughing Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which makes your symptoms/pain better**? Rest Rx Meds Elevation Ice Heat Massage

**What are you treating your pain with?** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any of these treatments?**  Injections Brace/s Physical Therapy

**Do you have any of the following? Check any that apply.**  none Blurred Vision Depression Irritability Tingling

Nausea Ringing in ears Stiffness Headaches Weakness Aches Burning Difficulty walking

Sleep disturbance Dizziness Ecchymosis Chronic fatigue Fever Heartburn Joint Stiffness Muscle Spasm

Numbness Pale bluish skin Pins and Needles Shortness of breath Sweating Bruises

**REVIEW OF SYMPTOMS Have you had any problems related to the following symptoms *Circle all that apply***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Constitutional Systems** |  |  |  |  |
| **Eyes** | Blurred | Double Vision | Vision Change | NONE |
| **Ear/Nose/Throat** | Earache | Sore Throat | Sinus Congestion | NONE |
| **Cardiovascular** | Chest pain | Shortness of Breath | Palpatations | NONE |
| **Respiratory** | Chronic Cough | Wheezes | Asthma | NONE |
| **Gastrointestinal** | Abdominal Pain | Nausea | Bowel Habit Changes | NONE |
| **Gentourinary** | Frequent Urination | Urine Retention | Kidney Problems | NONE |
| **Musculoskeletal** | Neck Pain | Back Pain | Joint Pain | NONE |
| **Skin** | Rash | Skin Discolor | Persistent Itch | NONE |
| **Neurologic** | Stroke | Weakness | Vertigo | NONE |
| **Psychiatric** | Anxiety | Depression | Sleep Disorder | NONE |
| **Endocrine** | Thirst Increase | Sweats | Thyroid Disease | NONE |
| **Hematologic** | Swollen Glands | Blood Clotting | Anemia | NONE |
| **Allergic** | Hay Fever |  |  | NONE |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Date

**What is your height and weight? Height:\_\_\_\_**Ft \_\_\_\_\_\_\_Inches  **Weight: \_\_\_\_\_\_\_\_\_\_\_** lbs\_\_\_\_\_\_\_\_\_\_\_oz

**Do you take anti coagulants (blood thinners) ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any surgeries you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**CURRENT PERSONAL ILLNESSES: *check all that apply***

None

Diabetes Heart Disease High blood pressure Elevated cholesterol Lung disease Thyroid disease Ulcers

Cancer Pacemaker Kidney disease Liver disease Seizures Psychiatric disorders HIV

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

**Is there a family history of medical conditions?**  Yes No

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**Marital Status:**  Single Married Divorced/Separated Widowed

**Smoking Status:**  Never Smoked Former Smoker Smoke Every day Sometimes Smoke how many packs a day?\_\_\_

**Alcohol Usage:**  Non-Drinker Social Drinker Alcoholic  **Have you been treated for alcohol addiction?**  Y N

**Drug Usage:**  Yes No If yes : Marijuana Cocaine Amphetamines Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been treated for drug addiction?**  Yes No

**MEDICATIONS: Pleas list current medications and doses**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ALLERGIES: Do you have any allergies?**  Yes No

Please List any allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Last Name First Name Date

**CONSENT INFORMATION**

**CONSENT TO TREAT**

This information I have given this office is complete and true to the best of my knowledge. I authorize Dr. Bachenheimer and Staff of Long Island Chiropractic & Wellness Center, to administer such procedures and they deem necessary. They implied no guarantee of cure.

Patients Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD**

The information I have given this office pertaining to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is true and complete to the best of my knowledge. I authorize the doctors and staff of Long Island Chiropractic & Wellness Center to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The Doctor has implied no guarantee of cure.

Parent/Guardian initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN ONLY**

Dr. Ronda Bachenheimer has advised me that x-rays can be hazardous to an unborn child. At the time and the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patients Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are changed directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

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

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

I hearby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

**Dr. Ronda Bachenheimer**

**2296 Hempstead Turnpike**

**East Meadow, NY 11554**

Patient’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have been provided with a copy of Long Island Chiropractic and Wellness Center’s HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_