WELCOME

Patient Information

Name_____

Home Address_____

City, State, Zip_____

e-mail_____

❑Single ❑Married ❑Divorced ❑Separated ❑Widow

Birth Date_____ Age _____

Sex: M F Soc. Sec. #_____

Occupation _____

Employer_____

Spouse's Name_____

Spouse's Birth Date_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

Insurance

Primary Insurance Co._____

Is patient covered by additional insurance? ❑Yes ❑No

Secondary Insurance Co._____

Please give us your insurance card(s) so we can make a copy.

Accident Information

Is condition due to an accident? ❑Yes ❑No

Type of accident? ❑Auto ❑Work

Date of accident_____

To whom have you made a report of your accident?

❑Auto Insurance ❑Employer ❑Worker Comp. ❑Other

Do you have an attorney representing you? ❑Yes ❑No

Name_____Phone_____

Billing

Who is responsible for this bill?_____

I will be paying today by:

❑Cash ❑Check ❑Credit Card ❑Care Credit

Phone Numbers

Home_____ Cell_____ Work_____ Ext_____

Who may we contact in case of emergency? _____Phone_____

Nearest relative not living with you_____Phone_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I understand that any insurance benefits which I may have are a contracted arrangement between myself and that insurance company. This office will assist in preparing notes, billing receipts and informational reports as needed to aid in insurance payment/ reimbursal. I realize that this office is not responsible to negotiate disputed benefits for me.

I am choosing to be treated, for today and all my future visits at this office, through the use of various types treatment which may include chiropractic manipulations, active release technique, instrument-assisted soft tissue mobilization (iastm), acupuncture, rehabilitation, diagnostic tests and several types of physiological modalities (physical therapy). I realize there is no guarantee of results, and have been informed that some risk of treatment do exist. These risks could include, but are not limited to: bruising, sprains, dislocation, fractures, strokes, and disk injury. While I do expect my doctor to use his/her best judgment to choose the most appropriate care for my condition, I agree that the doctor cannot foresee every possible complication or risk which could arise in my treatment.

In order to provide a continuum of care, this office will notify your primary care physician of treatment/ medical findings as deemed necessary.

My signature below signifies that I completely understand and agree to all of the above statements, and give my consent for treatment. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Witness: _____ Date: _____

Medical History Information

Last Name:				
First Name:	Middle:			
Medical Care Information				
Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:				
Address:	City:	State:	ZIP Code:	
Date of last Visit: / /	Date of last exam: / /			
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:				
Address:	City:	State:	ZIP Code:	
Date of last Visit: / /	Date of last exam: / /			
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:				
Have you had any other surgeries: ☐ Yes ☐ No If yes, when:				
Reason for Surgery:				

Present illness /Conditions:					
☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Seizures
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ S.T.D's
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ Pregnant- how far_____	
Other:					

Family History of illness:					
☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus
Other:					

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:			
Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous
Misc.:			

Signature: _____ Date: _____

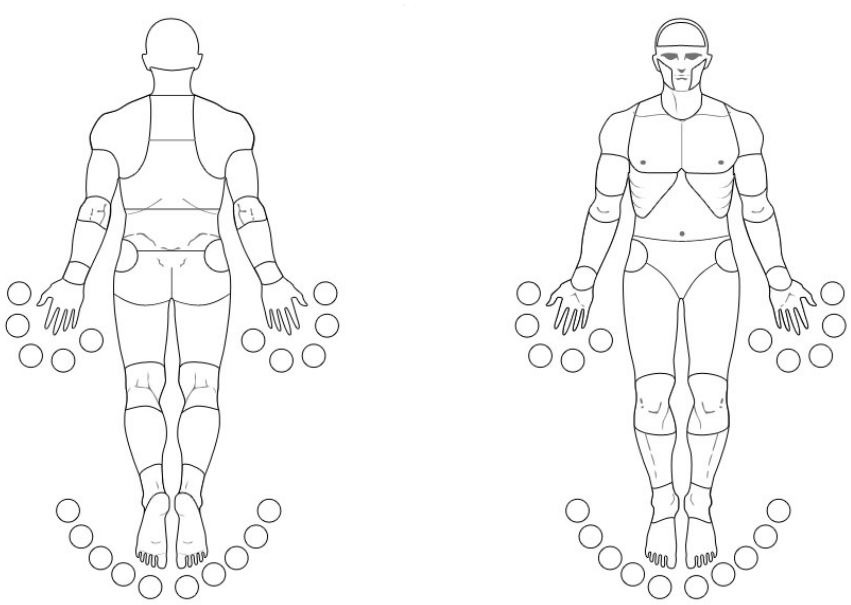
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

CURRENT COMPLAINTS

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow. Start with the area that bothers you the most.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



Area of Complaint		List first area from above that bothers you the most:
Location		☐ Left ☐ Right ☐ Both ☐ Center
Rate your pain		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
How often do you feel pain?		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
How bad is your pain?		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework ☐ Bright lights ☐ Loud Noises
Does the pain radiate/ shoot to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

Area of Complaint		List second area from above that bothers you the most:
Location		☐ Left ☐ Right ☐ Both ☐ Center
Rate your pain		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
How often do you feel pain?		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
How bad is your pain?		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
Does the pain radiate/ shoot to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

Area of Complaint		List third area from above that bothers you the most:
Location		☐ Left ☐ Right ☐ Both ☐ Center
Rate your pain		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
How often do you feel pain?		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Pain type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning
How bad is your pain?		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Lying Down ☐ Standing ☐ Sitting ☐ Stretching ☐ Range of Motion ☐ Nothing
What makes it worse?		☐ Movements ☐ Bending ☐ Twisting ☐ Weight Bearing ☐ Movements ☐ Neck flexion ☐ Sneezing ☐ Sitting ☐ Standing ☐ Walking ☐ Chewing ☐ Yawning ☐ Opening mouth ☐ Closing mouth ☐ Range of motion ☐ pushing/pulling ☐ Lifting ☐ Bright lights ☐ Loud Noises ☐ Watching T.V. ☐ Reading ☐ Working ☐ Driving ☐ Housework
Does the pain radiate/ shoot to any other locations?	Upper Body	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot ☐ Right Toes ☐ Left Toes
Described as		☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
At it's worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright light ☐ Sensitivity ☐ Loss of balance
Comments		

_____

Patient's Signature

Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Care Credit, Discover, MasterCard, or Visa. We will gladly discuss your proposed treatment and answer any questions relating to your insurance/ payment. Please review the following:

PATIENTS WITHOUT INSURANCE
We request that all visits be paid in full at the time of service. We offer the option of joining a third party discount pricing program. In this case we will only provide a simple receipt and **will not** file your insurance at a later date.

GROUP OR INDIVIDUAL INSURANCE
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic or other services offered in our office, although most policies do provide coverage. The amount they pay and the services they cover varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you get your full benefit. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

If we are participating providers for your insurance company, we have contracted to accept the U.C.R. (usual, customary, and reasonable) rate. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance (U.C.R.) determined by each carrier. However, if the insurance company determines that any service is "non-covered" or was "not medically necessary" or determines that you were not covered at the time of service, you are responsible in full for the service(s). Keep in mind the insurance company may not have your spine in their best interest, but the doctor uses his medical judgement about the care that is needed. **We suggest that you check your insurance policy coverage.**

"ON THE JOB" INJURY (Worker's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. Florida is a no fault state. We will bill (accept assignment) from your auto insurance, which usually covers 80%. We may accept Letter of Protection or Doctor's Lien from an attorney, bill your medical insurance, or collect cash at the time of service to cover any unpaid balance. If we accept a Letter of Protection or Doctor's Lien from an attorney, we will wait for the balance of payment at the time of settlement as long as you remain an active patient. If we bill your standard health insurance plan, you will be responsible for all co-pays and deductibles as they are incurred. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **(six)** months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE
We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, acupuncture, active release technique, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office files the forms for Medicare at no charge.

- We offer an interest free (up to 18 months) payment plan. Please ask for details.
- Returned checks are subject to a minimum additional fee of $30.00.
- Charges may also be made for broken appointments and appointments cancelled without 24 hours notice.
- Please bring in any checks/EOB that your insurance company mails you directly so we may apply it to your account.

I have read and understand the above payment policy. I understand that I am personally responsible for the total amounts due to Lawrence I. Teixeira, DC, PA for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Lawrence I. Teixeira, DC, PA for all costs of such collections efforts, including, but not limited to, all court costs and all attorney fees.

_____ _____

Patients Signature (or guardian or parent if a minor) Date