

WELCOME

3 Locations to Serve You Better!

PINES WEST
CHIROPRACTIC
18501 Pines Blvd., Suite 104
Pembroke Pines, FL 33029

EAST SIDE
CHIROPRACTIC
8228 Biscayne Blvd.
Miami, FL 33138

MARTINEZ
CHIROPRACTIC
12595 S.W. 137 Ave Suite 108
Miami, FL 33186

PATIENT INFORMATION

Patient: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Sex: M F Age: _____ DOB: _____
 Single Married Widowed Divorced
 Patient SS No. _____ Occupation: _____
 Employer: _____ Employer Phone No. _____
 Employer Address: _____
 Spouse's Name: _____ Birthdate: _____
 Patient SS No. _____ Occupation: _____
 Spouse's Employer: _____
 Children (Names & Ages) _____
 Whom may we thank for referring you: _____

PHONE NUMBERS

Home: _____
 Work: _____
 Ext: _____
 Best time to call _____
 Cell Phone: _____
 Email: _____

IN CASE OF EMERGENCY

Name: _____
 Relationship: _____
 Home #: _____
 Work #: _____

INSURANCE

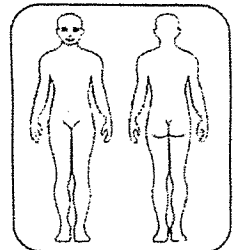
Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. Name _____
 Group or Card No. _____
 Is Patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS No. _____
 Relationship to Patient _____
 Insurance Co. Name _____
 Insurance I.D. No. _____

ACCIDENT INFORMATION

Is condition due to an accident?
 Yes No Date _____
 Type of Accident?
 Auto Work Home Other
 Explain Other: _____
 If yes, please tell our front office and fill out correct accident form in addition to this form.

PATIENT CONDITION

Reason for Visit: _____ Preventive health check up: Yes No
 When did your symptoms appear? _____ Is condition getting progressively worse? Yes No Unknown
 Mark an X on the picture where you continue to have pain, numbness or tingling. _____
 Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____
 Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting Burning
 Tingling Cramps Stiffness Swelling Other
 How many days in the last week did you feel the pain? _____ Is it constant or Occasional
 Does it interfere with your Work Family Life Sleep Recreation Exercise
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down Driving
 Do you suffer from any other health conditions? _____



PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____

Car accidents, falls, injuries: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin

Other _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD OR CURRENTLY HAVE:

- | | | | | |
|--|--|--------------------------------------|---|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Aids/H.I.V. | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Weak Immune System | <input type="checkbox"/> Carpal Tunnel Synd. |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Subluxations | <input type="checkbox"/> Repetitive Strain Synd. |
| <input type="checkbox"/> Chemical Dependency | | | | |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

- | | | |
|--|---|---|
| <p>MUSCULO-SKELETAL CODE</p> <input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Pain Between Shoulders
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Arm Pain
<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/> Difficult Chewing/Clicking Jaw
<input type="checkbox"/> General Stiffness
<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Knee Pain
<input type="checkbox"/> Hip Pain
<input type="checkbox"/> Hand/Wrist Pain
<input type="checkbox"/> Foot/Ankle Pain <p>GENERAL CODE</p> <input type="checkbox"/> Fatigue
<input type="checkbox"/> Allergies
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Fever
<input type="checkbox"/> Headaches <p>C-V-R CODE</p> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Blood Pressure
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Lung Problems/Congestion
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/> Stroke | <p>GASTRO-INTESTINAL CODE</p> <input type="checkbox"/> Poor/Excessive Appetite
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Frequent Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Weight Trouble
<input type="checkbox"/> Abdominal Cramps
<input type="checkbox"/> Gas/Bloating After Meals
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Black/Bloody Stool
<input type="checkbox"/> Colitis <p>GENITO-URINARY CODE</p> <input type="checkbox"/> Bladder Trouble
<input type="checkbox"/> Painful/Excessive Urination
<input type="checkbox"/> Discolored Urine <p>MALE/FEMALE CODE</p> <input type="checkbox"/> Menstrual Irregularity
<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Vaginal Pain/Infection
<input type="checkbox"/> Breast Pain/Lumps
<input type="checkbox"/> Prostate/Sexual Dysfunction
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other Problems _____

_____ | <p>NERVOUS SYSTEM CODE</p> <input type="checkbox"/> Nervous
<input type="checkbox"/> Numbness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Confusion/Depression
<input type="checkbox"/> Fainting
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Cold/Tingling Extremities
<input type="checkbox"/> Stress <p>EENT CODE</p> <input type="checkbox"/> Vision Problems
<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Ear Aches
<input type="checkbox"/> Hearing Difficulty
<input type="checkbox"/> Stuffed Nose <p>FAMILY HISTORY
 The following members have the same or similar problems as I do:</p> <input type="checkbox"/> Mother
<input type="checkbox"/> Father
<input type="checkbox"/> Brother
<input type="checkbox"/> Sister
<input type="checkbox"/> Spouse
<input type="checkbox"/> Child |
|--|---|---|

FEMALES ONLY

When was your last menstrual cycle? _____ Are you pregnant? Yes No Not Sure

EXERCISE	WORK ACTIVITY	HABITS
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Computers <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level Packs/Day _____ Drinks/Week _____ Cups/Day _____

What is most important in your Doctor/Patient relationship? _____

What are your health goals? pain relief only correct my health problem

Signature _____

WELCOME

ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT

PATIENT NAME: _____ Date: _____

Pines West Chiropractic is pleased that you have selected this group to provide for your chiropractic needs. Please review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. Please sign where indicated and return it to the receptionist. If you disapprove, we certainly respect your right of refusal. However, please be aware that, without your legal signature, we cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, we will have no alternative but to require that you be responsible for the cost of services rendered in full.

LIFETIME AUTHORIZATION STATEMENT/ASSIGNMENT FOR DIRECT PAYMENT

I hereby instruct and direct my current insurance carrier to pay by check or by electronic funds transfer payable to:

**Pines West Chiropractic
Dr. Joseph Buckley
18501 Pines Boulevard Suite 104
Pembroke Pines, FL 33029**

The medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Pines West Chiropractic and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment, including applicable co-payments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to Pines West Chiropractic. A photocopy of this assignment shall be considered as effective and as valid as the original. I understand that Pines West Chiropractic does accept assignment for Medicare and payments will be directed to Pines West Chiropractic. Should my account be referred for collection procedures, I will also pay reasonable attorney's fees and collection expenses.

CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Pines West Chiropractic. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/ or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic, there are some risks to treatment including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor during the course of care, based on the facts known at this time is in my best interest.

My signature certifies I have read, or have had read to me the above consent. I have also had the opportunity to ask questions and options to care have been explained. I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

RELEASE OF MEDICAL RECORDS

I hereby authorize Pines West Chiropractic to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement; Also to the patient's personal physician, referring physicians, or primary care physician. **I am aware that any/all information contained within my medical records/chart is the property of Pines West Chiropractic.**

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

Signature of Patient/Responsible Party

Printed Name

Signature of Witness

Witness Printed Name

Authorization form

Pines West Chiropractic

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Pines West Chiropractic** to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits **Pines West Chiropractic** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Pines west Chiropractic**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

[Pines West Chiropractic
18501 Pines Blvd. Suite 104
Pembroke Pines, FL 33029
Tel. (954) 432-3343

I have received a copy of the "Notice of Privacy Practices" and have read it.

Signed by:

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's Name

Date

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally Unable to work at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely Need help with all my personal care
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
3. Does your pain interfere with your traveling?
Travel anywhere I like Only travel to see doctors
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
4. Does your pain affect your ability to sit or stand?
No problems Can not sit/stand at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems Can not do at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems Can not do at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
7. Does your pain affect your ability to walk or run?
No problems Can not walk/run at all
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
8. Has your income declined since your pain began?
No decline Lost all income
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
9. Do you have to take pain medication every day to control your pain?
No medication needed On pain medication throughout the day
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors See doctors weekly
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem Never see them
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference Total interference
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help Need help all the time
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension Severe depression/tension
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems Severe problems
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Patient Signature

Doctor Signature

Massage Therapy Policy to ALL Patients

In fairness to our office, massage therapists, and other patients, we have made the following policy pertaining to Massage Therapy Appointments.

- ❖ A minimum 24 hour notice of cancellation is **REQUIRED**.
- ❖ A \$30 fee will be charged directly to you for cancelling with a notice of less than 24 hours.
- ❖ This charge is your responsibility and **will not** be submitted to your insurance company.
- ❖ Children under age 16 cannot be left unattended while you are receiving a massage.

Patient Signature

Date

Optional Appointment Reminder via Text or Email

Please choose an option:

Text Message

Phone Carrier: _____

Cell Number: _____

Email

Email Address: _____

Please choose a time:

One hour before

Four hours before

One day before

Chiropractic Newsletter:

Receive our interesting, health improving monthly newsletter online.

This monthly Chiropractic Newsletter delivers credible and current health information to help you and your family live healthier and happier. Please fill out the information below for your authorization.

Yes, I would like to receive this monthly newsletter.

No, I would not like to receive this monthly newsletter.

Email: _____

Signature: _____

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History (Record one diagnosis in your family history and the affected)				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		X		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only			
Height: _____	Weight: _____	Blood Pressure: _____ / _____	

