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._____

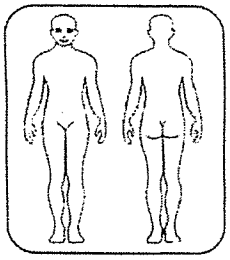
ACCIDENT INFORMATION

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:

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

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

MUSCULO-SKELETAL CODE

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Difficult Chewing/Clicking Jaw
- ❑ General Stiffness
- ❑ Shoulder Pain
- ❑ Knee Pain
- ❑ Hip Pain
- ❑ Hand/Wrist Pain
- ❑ Foot/Ankle Pain

GENERAL CODE

- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

C-V-R CODE

- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

GASTRO-INTESTINAL CODE

- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Gas/Bloating After Meals
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

GENITO-URINARY CODE

- ❑ Bladder Trouble
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

MALE/FEMALE CODE

- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❑ Vaginal Pain/Infection
- ❑ Breast Pain/Lumps
- ❑ Prostate/Sexual Dysfunction
- ❑ Venereal Disease
- ❑ Other Problems_____

_____

_____

NERVOUS SYSTEM CODE

- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

EENT CODE

- ❑ Vision Probers
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose

FAMILY HISTORY

The following members have the same or similar problems as I do:

- ❑ Mother
- ❑ Father
- ❑ Brother
- ❑ Sister
- ❑ Spouse
- ❑ Child

FEMALES ONLY

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

EXERCISE

- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

WORK ACTIVITY

- ❑ Sitting
- ❑ Computers
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

HABITS

- ❑ Smoking Packs/Day_____
- ❑ Alcohol Drinks/Week_____
- ❑ Coffee/Caffeine Drinks Cups/Day_____
- ❑ High Stress Level

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.

PINES WEST
CHIROPRACTIC

18501 Pines Blvd Suite 104
Pembroke Pines, Fl 33029
Tel: 954.432.3343 F 954.450.2565

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 your 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: _____

PINES WEST
CHIROPRACTIC

18501 Pines Blvd Suite 104
Pembroke Pines, Fl 33029
954.432.3343

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: _____ / _____