

# CONFIDENTIAL PATIENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Telephone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status: M S W D  
 Work Telephone \_\_\_\_\_ # Children \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Occupation \_\_\_\_\_ Your E-mail Address \_\_\_\_\_  
 Name and Address of Employer \_\_\_\_\_ Health Administrator's Name \_\_\_\_\_

## HEALTH INFORMATION

Have you had previous chiropractic care?  Yes  No  
 Main Complaint \_\_\_\_\_  
 Other Complaints \_\_\_\_\_  
 Are you pregnant?  Yes  No  
 Are you taking any medication?  Yes  No If yes, what? \_\_\_\_\_  
 Sign here to authorize x-rays and necessary tests \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_  
 Have you had similar conditions in the past? \_\_\_\_\_  
 Does this condition affect your family or social life?  Yes  No  
 What aggravates this condition? \_\_\_\_\_  
 \_\_\_\_\_  
 Other Doctors seen for this condition \_\_\_\_\_  
 \_\_\_\_\_  
 What helps your symptoms? \_\_\_\_\_  
 Have you had any surgery, falls or accidents?  Yes  No  
 When? \_\_\_\_\_ Please describe \_\_\_\_\_  
 \_\_\_\_\_  
 Date of last physical examination \_\_\_\_\_

## INSURANCE INFORMATION

Is this condition due to:  
 A work-related injury?  Yes  No An automobile accident?  Yes  No  
 If you answer yes to either of the above questions, please complete other side of form.  
 Do you have Major Medical Health Insurance?  Yes  No  
 Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 Does your insurance company require a referral from your Primary Care Physician?  Yes  No  
 If yes, name of PCP \_\_\_\_\_ Telephone \_\_\_\_\_

## Do You Suffer From:

	YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dudick Chiropractic 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 Dudick Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Guardian or Spouse's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

Complete only for:

**JOB INJURY INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Description of accident \_\_\_\_\_

Workman's Compensation Case # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Insurance Company Case # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Address \_\_\_\_\_

Hospitalized? \_\_\_\_\_ Name of Hospital \_\_\_\_\_ X-rays taken \_\_\_\_\_

Other Doctors seen \_\_\_\_\_

Are you working now? \_\_\_\_\_

Time lost from work \_\_\_\_\_ to \_\_\_\_\_ (dates)

Complete only for:

**ACCIDENT INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

How did accident occur?  Auto Collision  Other \_\_\_\_\_

If auto accident, were you  Driver  Passenger  Pedestrian

If auto collision, were you struck from  Behind  Right Side  Left Side  Front  Auto was Parked

Did your car strike the other(s) involved?  Yes  No

Or did the other car strike yours?  Yes  No  Undetermined

As a result of the accident, were traffic citations issued to you?  Yes  No

To the driver of the other car?  Yes  No

To the driver of your car?  Yes  No

List the extent of the injuries as you know them \_\_\_\_\_

Did you require post-accident hospitalization?  Yes  No

Check symptoms you have noticed since accident:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Head Seems Too Heavy     | <input type="checkbox"/> Loss of Memory    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring         | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Buzzing in Ears   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Balance   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Loss of Smell     | <input type="checkbox"/> _____         |

Symptoms other than above \_\_\_\_\_

Have you lost any days of work?  Yes  No Dates: \_\_\_\_\_

Insurance Companies involved:

My Company \_\_\_\_\_

Company of person responsible for injuries \_\_\_\_\_

Have you been contacted by an insurance adjuster or company representative regarding this claim?  Yes  No

Do you have an attorney that has advised you in this care?  Yes  No

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone: \_\_\_\_\_



**RE: Name of Patient** \_\_\_\_\_

**D.O.B.:** \_\_\_\_\_

**SS #** \_\_\_\_\_

**RECORDS RELEASE**

1) I hereby authorize Dudick Health to release and to permit the examination or copying of any of my medical records, X-rays, laboratory reports, and the results of all tests of any type or character to such persons as Dudick Health deems appropriate, including the information necessary to process a claim.

2) I hereby authorize my doctor or supplier of service to release and to permit the copying of any of my medical records, X-rays, insurance information, laboratory reports and the results of all tests of any type to Dudick Health, at 1789 Route 9, Clifton Park, NY 12065.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to Dudick Health for services provided.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**ACCEPTANCE OF PATIENT RESPONSIBILITY**

I understand that I am financially responsible for any charges incurred at this office, including copays, deductibles, and charges denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved, including the initial visits while waiting for approval. The insurance company will review any/all documentation submitted by Dudick Health for review for medical necessity and base their approval/denial upon this documentation.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

# CORE CHIROPRACTIC

## DUDICK HEALTH

1789 Route 9  
Clifton Park, New York 12065  
(518) 383-5847

FAX: 383-5848

38 South Pearl Street  
P. O. Box 10581  
Albany, New York 12201

### Questionnaire For On the Job Or Auto Injury (Compensation Or No Fault Case)

Name: \_\_\_\_\_

Any Time Lost From Work: \_\_\_\_\_ If So, Dates: \_\_\_\_\_

Name of Person to Whom You Reported Your Injury: \_\_\_\_\_

Do You Consider Yourself Disabled? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Totally Disabled? \_\_\_\_\_ Partially Disabled \_\_\_\_\_

Please Explain Details if Partially Disabled: (Not able to do regular job duties or work regular hours) \_\_\_\_\_

Were You Admitted to a Hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Give Dates: \_\_\_\_\_

Were You Treated by Other Physicians? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Give Names: \_\_\_\_\_

Do you have a history or evidence of prior injury, disease, or physical impairment? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Describe: \_\_\_\_\_

Do you have other insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ (A copy of your insurance card is required)

Company \_\_\_\_\_

Address \_\_\_\_\_

Please understand that it is the patient's responsibility to notify this office of any changes in work status and the date you return to work. Failure to do so could cause delayed insurance payments or total denial of all worker's compensation claims.

I understand that I am personally responsible for the normal office fee if the compensation or no fault carrier does not honor my claim.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)


I, \_\_\_\_\_, ("Assignor") hereby assign to Dr. Michael Dudick, ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)  
all rights privileges and remedies to payment for health care services provided by assignee to which I  
am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the  
Assignor and shall not pursue payment directly from the Assignor for services provided by said  
Assignee for injuries sustained due to the motor vehicle accident which occurred  
on \_\_\_\_\_, notwithstanding any prior written agreement to the contrary.  
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the  
assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the  
assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR  
OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING  
ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING,  
INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT  
INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO  
EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH  
VIOLATION.

\_\_\_\_\_  
(Print name of Patient) (Signature of Patient)  
\_\_\_\_\_  
(Date of signature)  
\_\_\_\_\_  
(Address)

Dr. Michael Dudick, DC   
(Print name of Provider) (Signature of Provider)  
\_\_\_\_\_  
(Date of signature)  
\_\_\_\_\_  
(Address)

# CORE CHIROPRACTIC DUDICK HEALTH

## NO FAULT INSURANCE INFORMATION

**\*\*\*New Regulations effective 02/01/2000- you must notify your insurance carrier within 30 days of accident. Failure to do so will result in non-coverage of benefits, and you will be responsible for any and all medical services provided in our office. \*\*\***

PLEASE PROVIDE US WITH INSURANCE COMPANY INFORMATION  
NOT THE AGENT/AGENCY INFORMATION

NO FAULT INSURANCE IS YOUR OWN AUTOMOBILE INSURANCE UNLESS YOU WERE A  
PASSENGER/PEDESTRIAN

Please print when filling out the requested information:

PATIENT NAME: \_\_\_\_\_ INITIAL DATE OF SERVICE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_

\_\_\_\_\_  
SOCIAL SECURITY#: \_\_\_\_\_

CAR INSURANCE CO. NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE#: \_\_\_\_\_

\_\_\_\_\_  
CONTACT PERSON: \_\_\_\_\_

INS. CLAIM# \_\_\_\_\_ INS. POLICY# \_\_\_\_\_

POLICYHOLDER NAME: \_\_\_\_\_

**IF WE DO NOT RECEIVE YOUR COMPLETED AND SIGNED INSURANCE FORMS, WE WILL HAVE NO CHOICE BUT TO HOLD YOU RESPONSIBLE FOR PAYMENT.**