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	☐	☐
Neck Pain	☐	☐
Arm or Shoulder Pain	☐	☐
Back Pain	☐	☐
Hip or Leg Pain	☐	☐
Chest Pain	☐	☐
Abdominal Pain	☐	☐
Sinus Trouble	☐	☐
Heart Trouble	☐	☐
Palpitation	☐	☐
Circulatory	☐	☐
High or Low Blood Pressure	☐	☐
Female Problems	☐	☐
Prostate Disorder	☐	☐
Kidney Problems	☐	☐
Bladder Problems	☐	☐
Lung or Bronchial Disorders	☐	☐
Digestive Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
General Fatigue	☐	☐
Morning Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

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:

☐ Headache	☐ Dizziness	☐ Light Bother Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatique	☐ Loss of Smell	☐ ______

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: ______

DUDICK HEALTH
Back & Neck Center

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 ________

October 2003

DUDICK HEALTH
Back & Neck Center

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

FAX: 383-5848
(518) 426-1182

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:* ____________________