

WELCOME TO BEDFORD HILLS FAMILY CHIROPRACTIC, PC

The purpose of this office is to educate as many families as possible about the spinal condition known as Vertebral Subluxations. Vertebral Subluxations damages an optimally functioning spine and nervous system. This impairs your ability to have optimal health. Your experience with this office will not be only be of healing, but also of learning the truth about **Optimal Health and Healing**.

PATIENT INFORMATION

Print Full Name _____ Today's Date _____
Street Address _____ City _____ State _____ Zip _____
Age _____ Date of Birth _____ Social Security # _____ Height _____ Weight _____
E-mail address _____
Home phone (_____) _____ Cell Phone (_____) _____ Business Phone (____) _____
Occupation _____ Employer _____
Emergency contact (name-Relationship) _____ (Where they could be reached) _____
Marital Status S M D W L/W Significant Other Name of Spouse _____
Names and Ages of Children _____
Whom may we thank for referring you to our office? _____
Or were you referred by Insurance Co. Our Website By our Location Found us in the Phone book
Insurance Co. _____ Policy # _____ Policy Holder _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns/complaints do you feel Chiropractic can address for you? _____

- Subluxations can put pressure on nerves for long periods of time. How long have you had the above complaints/concerns or When did it start? _____
- Nerve pressure & irritation can be constant or occasional. How Often do you have the above the complaint(s)? (constant/frequent/on&off) _____
- Irritation to different nerve fibers can create different sensations. Is your sharp, dull, throbbing, burning, numb, &/or achy (describe)? _____
- Subluxations can cause weakening of the entire spine. Is yours worse in the morning, evening, &/or after a specific activity? _____
- Do you know what caused it? _____
- Is it getting better or worse? _____
- Is this complaint/concern affecting your quality of life? (Please circle only those applicable to you)

Work:	Yes	No	Recreation:	Yes	No	Sleep:	Yes	No	Daily Routine:	Yes	No
School:	Yes	No	Walking:	Yes	No	Sitting:	Yes	No	Mood:	Yes	No
Exercise/sports	Yes	No	Eating:	Yes	No	Relationships:	Yes	No	Energy:	Yes	No

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Yes No With whom _____
How long under care? _____ Date of last visit: _____ Why did you stop? _____
Was there a particular health concern for which you consulted the chiropractor? _____

Have you ever been hospitalized? Yes No If yes, please explain for what and dates: _____

Have you ever had any surgeries? Yes No If yes, please explain for what and dates: _____

HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been exposed to any of the following on a regular basis, (past or present)?

Toxic chemicals Drugs (prescribed or not) Second hand smoke Other _____

If yes, please explain: _____

Do you have allergies to any foods? Yes No **If yes, please describe:** _____

Do you consume any of the following presently? Yes No

Coffee/caffeine Alcohol Tobacco Over the counter drugs Prescribed drugs

Please list all medications you are taking (prescribed and over the counter): _____

Note: It is imperative that you list all medications as they may have an influence on your care.

Please list all Supplements (vitamins/herbal supplements/homeopathics/others) you are taking: _____

Would you be interested in recommendations for nutritional supplements to help your current condition or other health issues? Yes No

HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma Yes No Loss of loved one Yes No Abuse Yes No

Work or School Yes No Divorce/separation Yes No Financial Yes No

Lifestyle change Yes No Parents divorce Yes No Illness Yes No

Past Health History

Have you had any problems in the past or presently with any of the following systems of the body? (describe symptoms or list illness/disease)

Muscle or Skeletal system: _____

Nervous System: _____

Gastro-intestinal: _____

Cardiovascular: _____

Genito-urinary: _____

Eyes Ears Nose Throat: _____

Male or Female Specific : _____

General: (fatigue/ allergies/ sleep diffic /fever / Headaches/other)

Family History:

	<u>Diabetes</u>	<u>Cancer</u>	<u>Heart Disease</u>	<u>Stroke</u>	<u>Description</u>
Father-living Yes/No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother-living Yes/No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother(s) # of ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sisters(s) #of ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adoption History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Wellness Objectives

At Bedford Hills Family Chiropractic, we are dedicated toward achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check all that apply that are the closest to your personal health goals:

- Symptom/Temporary Relief
- Restore Health
- Maximum Correction
- Wellness & Prevention
- Improved Performance

What are your expectations? As a result of my Chiropractic Care, I would like to: (Check all that apply)

- Feel better quickly
- Have a healthier nerve system
- Have a healthier spine
- Have optimum health on all levels

FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing. Please indicate your method of payment. Cash Check Credit Card

Please read the following and sign below.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare my necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office 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 I am personally responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of the office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions not for any medical diagnosis. Patient may obtain copies of their file upon request. Copying fees may apply.

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Stuart Weitzman permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature _____ Today's Date _____

Signature of Parent (for minor): _____ Today's Date _____

Thank you for choosing Dr. Stuart Weitzman of Bedford Hills Family Chiropractic.

We look forward to helping you develop a healthier spine and nervous system and *express your life to the fullest.*

HIPPA Awareness Form

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you would like a detailed copy of our Notice of Privacy Practices, we will gladly provide it to you upon request.

By signing this you understand and agree that your Personal Health Information (PHI) will be used in the following ways:

For Treatment: we may use and disclose your PHI to any healthcare provider to assist them in treating you.
For Payment: we may use and disclose your PHI for payment purposes.

Correspondence: We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out typical practice operations (TPO). We may mail to your home or other designated location any items that assist the practice in carrying out TPO, as long as they are marked personal and confidential. We may also, email you at home or other designated location any items that assist the practice in carrying out TPO. Items that may assist the practice include but are not limited: appointment reminder cards and patient statements.

You have a right to:

- Look at or get a copy of your health information. You must make your request in writing.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request additional restrictions on our use disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in case of emergency).
- Request that we communicate with you by different means or to different locations. Your request must be made in writing to our privacy officer.
- Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons.

Acknowledgement Form

I have reviewed the above information and have been given an opportunity to read the detailed Notice of Privacy Practices if I requested to do so.

Signature _____ Date _____
Patient or Legal Guardian (if a minor)

POLICY

At your next visit the doctor will go over the vital and valuable information found during today's exam and consultation. It is out policy that your spouse or both parents be present at your report of findings.

Bedford Hills Family Chiropractic
Dr. Stuart Weitzman
85 Adams Street
Bedford Hills, NY 10507
Tel. (914) 242-8810 Fax (914) 241-8719

Authorization to pay Doctor

I hereby authorize the _____ (Insurance Company) to pay by
check made out and mailed directly to:

Bedford Hills Family Chiropractic, P.C.
Stuart Weitzman, D.C.
85 Adams Street
Bedford Hills, NY 10507

the expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above named assignee and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

Name: _____

Address: _____

City/State/Zip: _____

Signature & Date _____