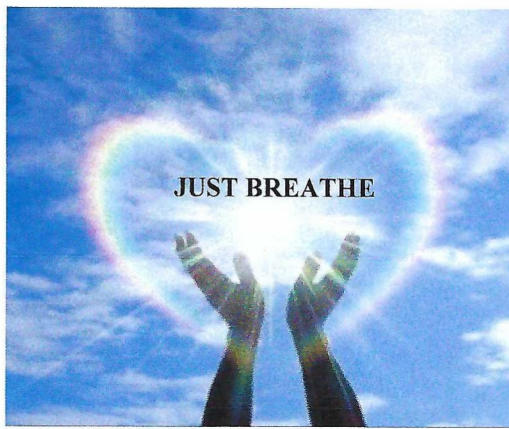




DOMINIC SMORRA, DC

18 WARD PLACE, CALDWELL, NEW JERSEY 07006 (973) 226-3321

WWW.CALDWELLCHIROPRACTOR.COM

PLEASE UPDATE YOUR INFORMATION

OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ Female ☐ Male Date of Birth: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Home Phone: _____ Cell Phone: _____

Email Address: _____ YES! Sign me up for Office Updates ☐

Employer: _____ Occupation: _____

Business Address: _____

Spouse's or Parent's Name: _____

Work Place: _____ Phone: _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____

Responsible Party: _____

Relationship to Patient: _____

Has your insurance changed? (If yes, please provide below) _____

Primary Insurance ☐ Self Pay ☐ (please check one)

Insurance Co: _____ Secondary: _____

Please provide your insurance cards..

Symptoms:

Reason for visit _____ When did you notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying down ☐ other _____

Type of Pain: ☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ shooting ☐ burning ☐ tingling
☐ cramps ☐ stiffness ☐ swelling ☐ other _____

Rate the severity of your pain. (1, mild or discomfort to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition:

☐ medication ☐ surgery ☐ physical therapy ☐ other _____

Name and address of other doctor(s) who have treated you for your condition: _____

Health History: check only those conditions which are applicable:

☐ AIDS/HIV ☐ CATARACTS ☐ HEPATITIS ☐ OSTEOPOROSIS ☐ SUICIDE ATTEMPT
☐ ALCOHOLISM ☐ CHEMICAL DEPENDENCY ☐ HERNIA ☐ PACEMAKER ☐ THYROID PROBLEM
☐ ALLERGY SHOTS ☐ CHICKEN POX ☐ HERNIATED DISC ☐ PARKINSON'S DISEASE ☐ TONSILLITIS
☐ ANEMIA ☐ DEPRESSION ☐ HERPES ☐ PINCHED NERVE ☐ TUBERCULOSIS
☐ ANOREXIA ☐ DIABETES ☐ HIGH CHOLESTEROL ☐ PNEUMONIA ☐ TUMORS, GROWTH
☐ APPENDICITIS ☐ EMPHYSEMA ☐ KIDNEY DISEASE ☐ POLIO ☐ TYPHOID FEVER
☐ ARTHRITIS ☐ EPILEPSY ☐ LIVER DISEASE ☐ PROSTATE PROBLEMS ☐ ULCERS
☐ ASTHMA ☐ FRACTURES ☐ MEASLES ☐ PROSTHESIS ☐ VAGINAL INFECTIONS
☐ BLEEDING DISORDER ☐ GLAUCOMA ☐ MIGRAINE HEADACHES ☐ PSYCHIATRIC CARE
☐ BREAST LUMP ☐ GOITER ☐ MISCARRIAGE ☐ RHEUMATOID ARTHRITIS ☐ VENEREAL DISEASE
☐ BRONCHITIS ☐ GONORRHEA ☐ MONONUCLEOSIS ☐ RHEUMATIC FEVER ☐ WHOOPING COUGH
☐ BULIMIA ☐ GOUT ☐ MULTIPLE SCLEROSIS ☐ SCARLET FEVER
☐ CANCER ☐ HEART DISEASE ☐ MUMPS ☐ STROKE ☐ OTHER _____

Dates of last exams: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing: ☐ Yes ☐ No Taking Birth Control: ☐ Yes ☐ No

Surgeries:

List any type of surgeries which you have had and the dates which they occurred:

Medications:

Please list all medications you are currently taking:

Allergies:

Daily Habits:

What type of exercise do you perform on a daily basis: { } None { } Moderate { } Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

What vitamins do you currently take: _____

What other kind of nutritional supplements do you take (if any)? _____

Do you smoke? { } No { } Yes How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much caffeine of caffeinated beverages do you consume on a daily basis? _____

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT (or patient if a minor)

DATE

Patient Agreement

(please read and initial each item)

____ I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures.

____ I hereby assign payment directly to the physician accepting this assignment of benefits.

____ I understand there are State Guidelines that dictate insurance carrier responsibility. I understand that NJ (for example) is a No Fault State.

- I understand this means that regardless of fault or circumstance (except work related instances), all claims for services rendered will be submitted to my personal automobile carrier.
- In the event I do not hold my own automobile insurance, I further understand that these State guidelines dictate that if I reside with a relative (relative eg – my blood, marriage, or adoption) who holds an automobile policy, the claims for services rendered will be the responsibility of that carrier.
- In the event that neither of the above apply, claims for services rendered will be the responsibility of the host vehicle (host eg – vehicle I was in at the time of accident.)
- I also understand there may be other mitigating circumstances that may alter who is the responsible carrier.

____ I understand that I may have a deductible and coinsurance as written in the policy of carrier deemed responsible for claims payment. I have been informed of my liability and understand I am personally financially responsible for these amounts.

____ I understand that this office may have agreed to accept a lien from myself and my attorney to defer payment of my responsibility until my case has been settled. I understand it is my responsibility to make sure both myself and my attorney have signed said lien and it is promptly returned to this office. I further understand that, ultimately, I am responsible for payment of any balances if there is no recovery from the settlement or if the settlement is less than the balance due this office.

____ I understand that I am responsible to complete any and all paperwork required by the designated auto insurance carrier and/or by this office. I further acknowledge that if I do not complete said paperwork (which results in payments not being made by the insurance carrier) that I am personally financially responsible for my bills in full.

____ I understand that the designated carrier may require me to attend an Independent Medical Exam. I also understand that if I do not attend, the insurance carrier may deem they are no longer paying for my claims. Furthermore, if I attend the IME and it is still deemed my care will no longer be covered, I understand it is my responsibility to inform this office immediately so that other arrangements can be discussed.

____ I understand that in the event this account becomes delinquent I agree to pay for all costs of collection, including but not limited to, attorney fees, court costs, and collection agency charges.

Dated: _____

Patient Name: _____

Patient Signature: _____