CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name_____ Social Security #_____

Address_____ City_____ State_____ Zip_____

Home Telephone_____ Work Telephone_____

Email Address_____ Fax#_____ Pager_____

Age_____ Birthdate_____ # Children_____

Marital Status: M S W D Occupation:_____

Spouse's Name_____ Spouse' Office Telephone_____

Referred by_____ Nearest Relative & Telephone_____

HEALTH INFORMATION: Have you had previous chiropractic care?_____

What is your major complaint?_____

_____

Other Complaints:_____

How long have you had this condition?_____ Have you had this or similar conditions in the past?_____

What activities aggravate your condition?_____

Is this condition getting progressively worse? Yes No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with you: Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good?_____

Other doctors who treated this condition_____

_____

List surgical operations and years:_____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers

☐ Insulin ☐ Birth control pills ☐ Others_____

Age of mattress____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe:_____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

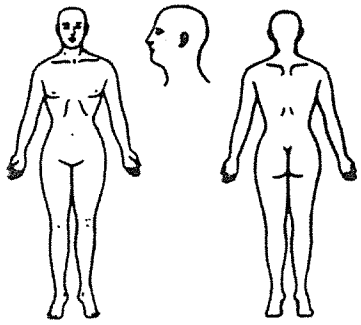
Describe:_____

Lafayette Street Chiropractic Center P.C.
123 Clifford St. Ste. 105
Newark, NJ 07105

CONFIDENTIAL PATIENT CASE HISTORY

Date of Last Physical Examination_____

Please mark your areas of pain on the figures below



Have you Ever Suffered From:

1. Dizziness_____
2. Backaches_____
3. Heart Trouble_____
4. Diabetes_____
5. Arthritis_____
6. Headaches_____
7. Asthma_____
8. Neuritis_____
9. Digestive Disorders_____
10. Nervousness_____
11. Sinus Trouble_____
12. Neck Pain_____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No

If yes: Name of Company_____ Policy #_____

Are you covered by Medicare? ☐ Yes ☐ No

If yes: Health Insurance# _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office 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 this Chiropractic Office will be credited to my account upon 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

☐ MasterCard ☐ Visa ☐ American Express Card #_____ Exp. Date_____

All accounts not paid within 90 days will *automatically* be put through on your credit card.

Patient's Signature:_____ Date_____

Guardian or Spouse's Signature_____

Doctor's Signature_____

FAMILY HEALTH INFORMATION. (Many health problems are the result of heredity spinal weaknesses: thus information about your family members give us a better picture of your total health picture.)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

Lafayette Street Chiropractic Center P.C.
123 Clifford St. Ste. 105
Newark, NJ 07105

PERSONAL INJURY QUESTIONNAIRE

Information about You

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex ( )F ( )M Email: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Auto Ins. Co. _____ Claim # _____

Address _____ City _____ State _____ Zip _____

Adjuster's Name _____ Adjuster's Phone # _____ Ext. _____

Policy Holder's Name (if other than self) _____

Information about Your Attorney

Name _____ Ph _____ Fx _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Names _____

Information about Your Accident

Date of Accident _____ Time of Day _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of people in your vehicle? _____ Were you wearing seatbelts? ( ) Yes ( ) No

What direction was you headed? ( ) North ( ) East ( ) West ( ) South

What direction was the other vehicle headed? ( ) North ( ) East ( ) West ( ) South

On (name of street) _____

Were you struck from: ( ) behind ( ) front ( ) Left Side ( ) Right Side

Approximate speed of your car _____ mph Other car _____ mph

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____

Were policy notified? ( ) Yes ( ) No

In your own words, please describe the accident: _____

_____

_____

Did you have any physical complaints before the accident? ( ) Yes ( ) No

If yes, please describe: _____

_____

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

What are your present complaints and symptoms? _____

_____

_____

Where were you taken after the accident? _____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please write down their names: _____

Since the injury occurred, are your symptoms ( ) improving ( ) getting worse ( )Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) Headache	( ) Irritability	( ) Numbness in toes	( ) Flushed face
( ) Neck pain	( ) Chest pain	( ) Shortness of breath	( )Buzzing in ears
( ) Stiff neck	( ) Dizziness	( ) Fatigue	( ) Loss of balance
( ) Difficulty sleeping	( ) Head is heavy	( ) Depression	( ) Fainting
( ) Back pain	( ) Pin/Needles in arms	( ) Light sensitive eyes	( ) Loss of smell
( ) Nervousness	( ) Pin/Needles in legs	( ) Loss of memory	( ) Loss of taste
( ) Tension	( ) Numbness in fingers	( ) ringing ears	( ) Diarrhea
( ) Cold feet	( ) Cold hands	( ) Upset stomach	( ) Constipation
( ) Cold sweats	( ) Fever	( ) _____	( ) _____

Do you have any congenital (from birth) factors which relate to this problem? _____

_____

Do you have any previous illnesses that relate to this case? ( ) Yes ( ) No

If yes, please describe: _____

_____

Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accident(s) as well as injuries suffered:

_____

_____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No

Last day worked: _____

Type of Employment: _____

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe: _____

_____

Other pertinent information: _____

_____

_____ _____

Date Patient's Signature

PLEASE CHECK ONLY SIGNIFICANT COMPLAINTS & ANSWER OTHER QUESTIONS

___ Headache	___ Neck pain	___ Back pain
___ Dizziness	___ Room Spins	___ Chest pain
___ Blurred Vision	___ Eye pain	___ Rib pain
___ Pain behind ear	___ Ringing or buzzing in ears	___ Ankle pain
___ Pain in the face	___ Impaired hearing	___ Foot pain
___ Jaw pain	___ Pain with chewing	___ Sadness
___ Clicking or popping noises when opening and closing your mounth		___ Vomiting
___ Stiffness in the jaw joints	___ Arm pain	___ Bleeding
___ Shoulder pain	___ Hand pain	___ Constant thirst
___ Wrist pain	___ Difficulty swallowing	___ Nausea
___ Throat pain	___ Knee pain	___ Rash
___ Teeth clenching or grinding	___ Leg pain	___ Frequent urination
___ Jaw has locked open	___ Insomnia	___ Loss of balance
___ Difficulty / Painful breathing	___ Diarrhea	___ Forearm pain
___ Abdominal pain	___ Bruising	___ Finger pain
___ Hip pain	___ Constant hunger	
___ Thigh pain	___ Snoring	
___ Anxiety	___ Spinning feeling	

___ I have had previous injury

___ There is a history of medical problems unrelated to my injury.

Please list current medications.....

Name:_____ _____ _____

PLEASE PRINT PLEASE SIGN DATE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH RECORDS AND INFORMATION

TO: _____

ADDRESS: _____

PATENT NAME: _____

ADDRESS: _____

PATIENT SOCIAL SECURITY # _____

PATIENT DATE OF BIRTH: _____

By signing this authorization form I, _____ authorize the Health Care Provider, as defined by N.J.A.C. 22-3.2, to disclosure my health records and information (i.e., information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act ("HIPPA") of 1996) in the manner described below. The Health Care Provider will not condition treatment on my decision to sign this authorization.

I have signed this form voluntarily to document my wishes regarding the disclosure of the health information described below.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the Health information I authorize to disclose:

All information, including information deemed sensitive, office records, imaging films and interpretations including x-rays and MRI's, report, test results, billing records, and like relating to my examination, consultation, treatment, therapy, or admission.

I understand that the information to be released from my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), genetic information, and tuberculosis information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The approximate date of first examination, treatment, therapy, admission to hospital or other health care facility, or consultation is _____

2. Description of Each Purpose for the Requested Disclosure: I authorize my health information to be disclosed for the following specific purposes:

The inspection and copying thereof in connection with civil discovery during a pending legal proceeding in which I am a party.

3. Person/s Organization Authorized to Receive and or Use my Health information. I authorize the following person(s) and/or organization(s) to receive my health information from the Health Care Provider ant to use or disclose such information for the purpose listed above. I understand that the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and may be re disclosed without obtaining my authorization.

Any person associated with *Lafayette Chiropractic Center at 123 Clifford St. Suite 105 Newark New Jersey 07105, (973) 466-3810,* or their authorized representative.

4. Right to Revoke. I understand that I have the right to revoke this authorization at any time and that my revocation of the authorization must be in writing. I understand that any such revocation must include my name, address, telephone number, the date of this authorization, and my signature, and I should send it to the Health Care Provider listed above. I am aware the revocation will not be effective as to uses and or disclosures of my health information that have been made in reliance upon this authorization prior to the receipt of a proper revocation.

5. Expiration of Authorization. This authorization will expire upon the occurrence of the following event(s) or upon my revocation in accordance with paragraph 4 above:

The final disposition of the legal proceeding to which I am a party and in connection with I make this Authorization.

PATIENT SIGNATURE
I have had the opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ **Date:** _____/_____/_____

Lafayette Street Chiropractic Center P.C.
123 Clifford St. Ste. 105
Newark, NJ 07105

LAFAYETTE CHIROPRACTIC CENTER
123 CLIFFORD STREET, SUITE 105
NEWARK, NJ 07105
PHONE 973-466-3810
FAX: 973-466-3818

Jesse J. Burrini, D.C.

AUTHORIZATION TO RELEASE INFORMATION

I authorize and instruct my Insurance Carrier, _____, to provide all information requested by Lafayette Chiropractic Center office of Jesse Burrini D.C necessary, including copay, deductible and policy information, to verify benefit eligibility, pre-certify procedures, and coverage benefits pursuant to claim processing under this policy.

Patient Name (Printed) _____

Patient Signature: _____

Date: _____

Lafayette Chiropractic Center P.C.
123 Clifford Street, Suite 105
Newark, NJ 07105

ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

I IRREVOCABLY ASSIGN TO LAFAYETTE STREET CHIROPRACTIC CENTER ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY LAFAYETTE STREET CHIROPRACTIC CENTER. I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY LAFAYETTE STREET CHIROPRACTIC CENTER TO BE RELEASED TO LAFAYETTE STREET CHIROPRACTIC CENTER. I IRREVOCABLY AUTHORIZE LAFAYETTE STREET CHIROPRACTIC CENTER TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME INCLUDING FILING FOR P.I.P.ARBITRATION & /OR IN AMERICAN ARBITRATION ASSOCIATION & SUPERIOR COURT. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO LAFAYETTE STREET CHIROPRACTIC CENTER. I IRREVOCABLY AUTHORIZE LAFAYETTE STREET CHIROPRACTIC CENTER TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITY, AND AUTHORIZE LAFAYETTE STREET CHIROPRACTIC CENTER TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO LAFAYETTE STREET CHIROPRACTIC CENTER AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID ANY PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND ITS NATURE AND EFFECT.
A PHOTOCOPY OF THIS ASSIGNMENT WILL ACT AS THE ORIGINAL.

PATIENT SIGNATURE: _____

DATE: _____

Insurance company:
Following is (are) the assignment(s) of benefits signed by your insured(s), the above named patient(s), pursuant to the policy terms. Failure to contact us in writing disapproving this assignment within forty-eight (48) hours will be deemed consent to same and we will proceed with treatment accordingly.

LAFAYETTE CHIROPRACTIC CENTER
123 CLIFFORD STREET - SUITE 105
NEWARK, NJ 07105
PHONE 973-466-3810

Jesse J. Burrini, D.C.

SIMPLE AGREEMENT FORM

Patient authorizes the Doctor to deposit checks received on Patient's account when made out to the patient.

Patient agrees to immediately forward any and all checks issued from insurance carrier to the provider, but mailed to the patient's address.

Patients Name: _____

Patients Signature: _____

Date: _____