WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

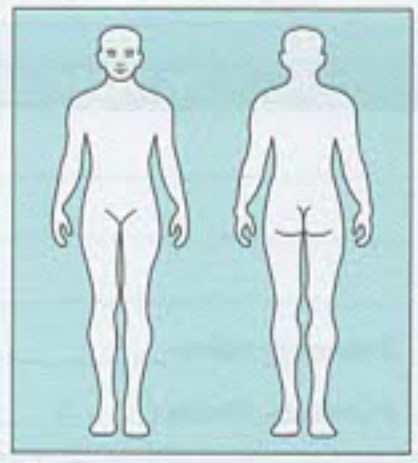
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

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

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test _____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____	
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharmacy Phone (____)_____		

Martuccio Chiropractic & Health Center, Inc.

369 Niles - Cortland Rd. S.E.
Warren, Ohio 44484

Telephone (330) 856-9595
Fax (330) 856-1411

Notice of Privacy Practice Patient Acknowledgment

Patient Name: _____ Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices within plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes. Treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and I may revoke such authorization.
- My individual rights with the respect to protect health information and a brief description of how I may exercise these rights in relation to.

- The right to complain to this practice and to the Secretary of Health and Human Services if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restrictions.
- The right to receive confidential communication of protected health information.
- The right to inspect and copy protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of it's Notice of Privacy Practices and to make new provisions effective of all the protected health information that it maintains. If changes occur, this practice will provide me with a revised notice of Privacy practices upon request.

Signature: _____ Date: _____

If patient is less than 18 years of age, a parent or legal guardian must sign.

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Warren, Ohio 44484

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Notice of Policy
Regarding Requests / Records
Patient Agreement

Patient Name. _____

Date of Birth. _____

I have received and understand the practice of Notice of Policy Regarding Requests / Records written in plain language. The notice explains in detail the policy of Martuccio Chiropractic and Health Center regarding requests for copies of records, diagnostic results or specialized reports which requires a 7 (seven) day advance notice. Appropriate documentation, narrative report writing, copying, postage, staff and handling fees will apply.

I understand that this practice reserves the right to change the terms of the Notice of Policy Regarding Requests / Records. If changes to the policy occur, this practice will provide me with a revised Notice of Policy Regarding Requests / Records Practice upon request.

Signature. _____

Date. _____

If patient is less than 18 years of age, a parent or legal guardian must sign.

Martuccio Chiropractic & Health Center, Inc.

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Warren, Ohio 44484

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Authorization to Release Records

To: _____
(Doctor / Hospital Name)

_____
(Doctor / Hospital Address)

I hereby authorize and request you to release records to:

Martuccio Chiropractic & Health Center, Inc.
369 Niles-Cortland Rd. S.E.
Warren, Ohio 44484

The complete medical records in your possession, concerning my illness and/or treatment during the period.

To: _____ From: _____

Patient's Name: _____

Patient's D.O.B.: _____

Patient's Address: _____

Patient's Social Security Number: _____

Patient's Name (Please Print): _____

Signature: _____ **Date:** _____

If patient is less than 18 years of age, a parent or legal guardian must sign.

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369 Niles - Cortland Rd. S.E.
Warren, Ohio 44484

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Insurance Authorization and Assignment Order

I hereby authorize and assign payment directly to, *Martuccio Chiropractic Clinic, Inc., the benefits due to me out of indemnity under the terms of my policy issued by,*

_____

(Name of Patient's Insurance Company)

Payment is authorized and assigned upon your receipt of this offices itemized statement for services rendered to me. This policy was in full force and effective at the time services were rendered. Payment of this amount as herein directed, in the whole or part, shall be considered the same as if paid, by your company, directly to Martuccio Chiropractic Clinic, Inc.

_____

(Insured Patient's Name)

_____

(Patient's Address / Phone Number)

_____

(Policy Number)

Patient Name (Please Print):_____

Signature:_____ Date:_____

Witness Signature:_____ Date:_____

If patient is less than 18 years of age, a parent or legal guardian must sign.

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Financial Agreement

1. Your *INITIAL VISIT* to our office is to be paid in full at the time of each visit by cash, check or credit card, except in cases when your insurance company has a fixed co-payment. (Anthem, United Healthcare, Medical Mutual, etc.).
2. All services rendered to you by our office are charged directly to you. You are personally responsible for *ALL* payments regardless whether or not our office directly billed your insurance.
3. Payments are due at the time of service or at the beginning of the week. All insurance assignment patients must pay their deductible, *IN FULL*, and their co-payments at the time of service.
4. After 90 (ninety) days from the date of service, if your insurance company has not paid our office, your balance is due *immediately* to this office.
5. If your injury is work related and you have not notified our office at the *BEGINNING* of care, your balance is due *immediately* to this office.
6. If your injury is due to an automobile accident, *BEFORE YOU COMMENCE CARE*, a lien must be signed by the patient and your attorney in triplicate.
7. A $25.00 (twenty-five dollar) statement fee will be added to every statement sent, until balance is paid in full.
8. A 7.5% interest fee will be added to the account with every statement sent, until balance is paid in full.

Patient Name (Please Print):_____

Signature:_____ Date:_____

If patient is less than 18 years of age, a parent or guardian must sign.