Dr. Barry W. Levitt, D.C., P.A.
Dr. Erick A. Daes, D.C., P.A.
8955 S.W. 87th Court
Miami, Florida 33176
305-233-5700 305-279-2222

PATIENT INFORMATION

(IF THIS IS RELATED TO AN AUTO ACCIDENT OR WORK INJURY PLEASE TELL THE FRONT DESK.)

NAME_____ DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE_____ CELL_____

E-MAIL_____

Please print clearly email address..{Your email will not be shared with 3rd parties. It will be used to communicate with you from our office and to send periodic reminders, newsletters and information of interest}

BIRTHDATE_____AGE_____SEX_____ STATUS---M S W D

HEIGHT_____ WEIGHT_____

OCCUPATION_____EMPLOYER_____

WORK TELEPHONE_____

SPOUSE'S NAME_____BIRTHDATE_____

SPOUSE'S EMPLOYER & PHONE_____

NAMES & AGES OF CHILDREN_____

NAME AND PHONE OF EMERGENCY CONTACT_____

WHO MAY WE THANK FOR REFERRING YOU_____

INSURANCE INFORMATION

NAME OF COMPANY_____

INSURED NAME AND DATE OF BIRTH _____

GROUP #_____ IDENTIFICATION #_____

*** PLEASE REMEMBER TO GIVE THE FRONT DESK A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE**

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PATIENT HISTORY FORM

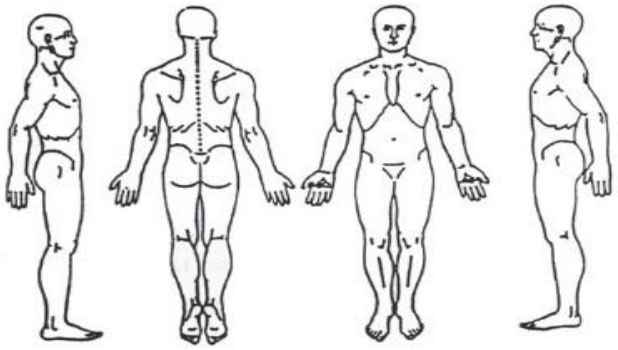
Patient's Name_____ **Date**_____

REASON(S) FOR VISIT

Please circle all that apply: Work, Sport, Auto Accident, Spinal Pain, Spinal Curvature correction (including Scoliosis), Headaches, Arm and/or Leg pain/sciatica, Back Pain, Muscle Spasms, Preventive Checkup/Care, Misaligned Vertebrae, "Slipped disc" [bulge or herniation], Loss of Strength or feeling in the arm/hand or thigh/leg.

When did the condition begin? _____
Explain what happened _____

How often do you experience your symptoms? Please check one:
Constantly _____(76-100% of the day) Frequently _____ (51-75% of the day)
Occasionally _____ (26-50% of the day) Intermittently _____ (0-25% of the day)
What describes the nature of your symptoms?
Sharp _____ Shooting _____ Dull Ache _____ Burning _____ Numb_____ Tingling_____
Mark the appropriate symbol on the picture where you are having pain.
Aching ****** Stabbing ///////// Numbness --------- Burning XXXXXX Pins and Needles 000000



Indicate the average intensity of your symptoms: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

How are your symptoms getting? Better_____ Worse_____ Not Changing_____

Has it interfered with your: Work_____ Sleep_____ Daily Routine_____ Recreation_____

Have you ever been treated by a medical physician for this condition? YES ___ NO ___

Have you ever been treated by a chiropractor? YES ___ NO ___

List all medical conditions: _____

List medications/birth control: _____

List major surgeries: _____

Do you have any allergies/asthma? YES ___ NO ___ If so, please list: _____

If female, are you pregnant? YES ___ NO ___ Date of last menstruation_____

Do you smoke? YES ___ NO ___ How much_____

Do you use other substances? YES ___ NO ___

Do you consume alcohol? Never_____ Rarely_____ Occasionally_____ Frequently _____

Signature _____

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Medical History

Please Check and Describe Below any of the following you have had in the last 12 months and/or ever received treatment for:

MUSCULO-SKELETAL Describe Checked Item:

____Low Back Pain ____Pain Between Shoulders ____Neck Pain
____Joint Pain/Stiffness ____Walking Problems ____Arm Pain
____General Stiffness ____Difficult Chewing/Clicking Jaw

GENITO-URINARY

____Painful/Excessive Urination ____Discolored Urine ____Bladder Trouble

CARDIO-VASCULAR-RESPIRATORY

____Chest Pain ____Short Breath ____Blood Pressure Problems
____Irregular Heartbeat ____Heart Problems ____Lung Problems/Congestion
____Varicose Veins ____Ankle Swelling ____Stroke

NERVOUS SYSTEM

____Nervous ____Numbness ____Paralysis ____Dizziness
____Forgetfulness ____Confusion/Depression ____Fainting ____Convulsions
____Cold/Tingling Extremities ____Stress ____Hearing Difficulty

EYES, EARS, NOSE, THROAT

____Vision Problems ____Dental Problems ____Sore Throat
____Ear Aches ____Stuffed Nose

GENERAL

____Fatigues ____Allergies ____Headaches ____Fever

MALE/FEMALE

____Menstrual Irregularity ____Menstrual Cramps ____Vaginal Pain/Infection
____Breast Pain/Lumps ____Prostate/Sexual Dysfunction ____Other: _____

GASTRO-INTESTINAL

____Poor/Excessive Appetite ____Excessive Thirst ____Frequent Nausea
____Vomiting ____Diarrhea ____Constipation
____Hemorrhoids ____Liver Problems ____Gall Bladder Problems
____Weight Trouble ____Abdominal Cramps ____Gas/Bloating after meals
____Heartburn ____Black/Bloody Stools ____Colitis

DESCRIBE ABOVE CHECKED ITEMS:

Symptom	**Date Last Experienced**	**Treatment Received**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT NAME: _____ Doctor Initials: _____
PATIENT SIGNATURE: _____ Date: _____

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Patient Consent for Use of Disclosure of Protected Health Information

I give my consent for the above Doctors to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO)

Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The above stated Doctors reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Private Practices may be obtained by forwarding a written request to the above stated Doctors.

With this consent, the above stated Doctors may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the above Doctors may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as they are marked Personal and Confidential.

With this consent, the above stated Doctors may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the above stated Doctors' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the above stated Doctors may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print name of Patient or Legal Guardian **Date**

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I understand the information on all forms and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes in my medical status.

I authorize the staff to perform any necessary services during the diagnosis and treatment. I also authorize the provider and/or managed care organizer to release any information required to process insurance claims.

I authorize Dr. Barry W. Levitt or Dr. Erick A. Daes to provide medical services to me.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collection your account. I understand that I am financially responsible for all changes whether or not paid by the insurance companies.

I authorize the release of any medical information necessary to process this claim including but not limited to all of my insurance companies. I also request payment of government benefit either to myself or to the party who accepts assignments below.

Signature on File:

I authorize payment of medical benefits to the undersigned physician(s) or supplier of service. I authorize physician to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my physician. I permit a copy of this authorization to be used in place of my original signature. I authorize use of this form on all my insurance submissions.

_____ _____

Patient's Signature **Date**

_____ _____

Doctor's Signature **Date**

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INFORMED CONSENT TO TREAT

(Patient: Please discuss any questions or concerns with the Doctor before signing this consent.)

I hereby request and consent to the performance of manipulation (adjustments) and other procedures including diagnostic x-rays and various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible.)

I have had the opportunity to discuss with the doctor and/or with other office or clinical personnel the purpose and benefits of Manipulations (adjustments) and other treatments outlined below. Alternatives to treatments have been reviewed.

I understand that I will be receiving one or more of the following treatments: Manipulations (adjustments), Mobilization Therapy, Hot/Cold Packs, Electrical Stimulation, Inferential Current, Myofascial Release, Traction, Therapeutic Exercises, Massage, Spinal Decompression, Mechanical Traction, Passive Mobilization, Taping or Splinting.

I understand that Manipulation (adjustments) is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding treatment that I have requested or authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Signature of Patient (or guardian) **Date**

_____ _____

Doctors Signature **Date**