CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

REFERRED BY:____
LAST NAME:_______________________ FIRST NAME:____________________ MI__________
ADDRESS: ____
CITY:_____________________________ STATE:_______________ ZIP:________________
HOME # (____)_______________ WORK # (____)__________________ CELL# (___)__________________
EMAIL:____
AGE______ DATE OF BIRTH ____/____/____ SEX M F SOC. SEC. # _______-_______-_______
MARITAL STATUS S M D W SPOUSE NAME:_______________________________
TYPE OF INS.? AUTO WORKER'S COMP PERSONAL INJ PRIVATE HEALTH MEDICARE NONE
PRIMARY CARE PHYSICIAN:____
ADDRESS:____
TELEPHONE:(____)___________________ FAX:(____)______________________

EMPLOYER INFORMATION

OCCUPATION ____
EMPLOYER ____
ADDRESS ____
CITY ______________________________ STATE ______________ ZIP _________________
PHONE # ________________________________

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME ________________________________ **2.** INSURED'S SS# ____ / ____ / _____
3. PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD ________________________
4. NAME OS INSURANCE CO. ____
5. ADDRESS: ____
6. INSURANCE PHONE # (___)_________________________ **7.** POLICY # _______________________
SECONDARY INSURANCE
8. INSURED'S NAME ____ **9.** SS# ______/______/______
10. NAME OF INSURANCE CO.____
11. ADDRESS: ____
12. INSURANCE PHONE # (___)_________________________ **13.**POLICY # _______________________

CONFIDENTIAL NEW PATIENT QUESTIONAIRE (CONT.)

PATIENT HEALTH INFORMATION

1. MAJOR COMPLAINT(S) ____
____
____

2. CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past		Present	Past	
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pain	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Chronic Sinusitis
☐	☐	Headache	☐	☐	General Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Disturbance	☐	☐	Abdominal Pain
☐	☐	Nausea	☐	☐	Difficulty in Swallowing
☐	☐	Shoulder Pain	☐	☐	Depression
☐	☐	Pain in Upper Arms or Elbows	☐	☐	High Blood Pressure
☐	☐	Hand Pain	☐	☐	Angina
☐	☐	Pain in Upper Leg or Hip	☐	☐	Heart Attack
☐	☐	Pain in Lower Leg or Knee	☐	☐	Stroke
☐	☐	Pain in Ankle or Foot	☐	☐	Asthma
☐	☐	Swelling/Stiffness of Joints	☐	☐	Cancer
☐	☐	Jaw Pain	☐	☐	Emphysema (Lung Disorde
☐	☐	Tinnitus (ear noises)	☐	☐	Arthritis
☐	☐	Rapid Heart Beat	☐	☐	Diabetes
☐	☐	Chest pain	☐	☐	Ulcer
☐	☐	Loss of Appetite	☐	☐	Bladder Infection
☐	☐	Blood Disorder	☐	☐	Colitis

3. Please describe the character of your current pain: ☐ Sharp/Shooting ☐ Tingling ☐ Aches ☐ Dull
☐ Soreness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning
4. Did your problem begin: ☐ Due to an accident ☐ Multiple incidents ☐ Gradually ☐ No specific reason
☐ other ____
5. Describe how your problem began:____
____
6. What treatment have you received for this present condition? ☐ Surgery ☐ Spinal injections ☐ Physical Therapy
☐ Chiropractic ☐ Medicine ☐ X-ray ☐ Acupuncture ☐ Other ________________________________
7. Have you been treated previously for the same condition? ☐ Yes ☐ No
If yes, by: ☐ MD ☐ Chiropractor ☐ Physical Therapist ☐ Other________________________________
8. What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting
☐ Movement/Exercise ☐ Inactivity ☐ other ____
9. What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting
☐ Movement/Exercise ☐ Inactivity ☐ other ____
10. Do you work? ☐ Yes ☐ No If yes: Sitting more then 50% of workday ☐ Light manual labor
☐ Other ____

CONFIDENTIAL NEW PATIENT QUESTIONAIRE (CONT.)

11. Are your complaints affecting your ability to work or otherwise be active?
    - ☐ No effect ☐ Some physical restrictions (able to perform light duty housework and household tasks)
    - ☐ Need limited assistance with everyday tasks ☐ Need assistance often
    - ☐ Have a significant inability to function without assistance ☐ Cannot care for self

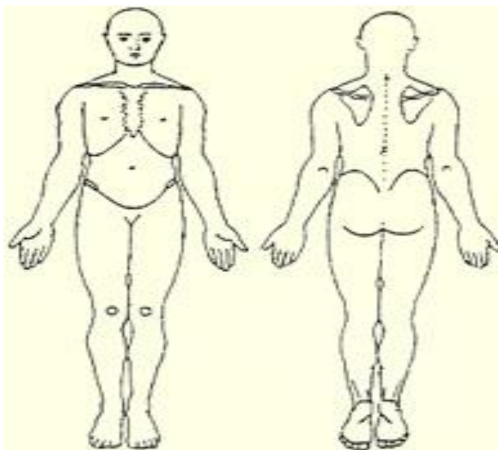
12. Are you currently taking medicine? ☐ Yes ☐ No If yes: ____
    ____
13. Are you allergic to any drugs or medication? ☐ Yes ☐ No If yes: ______________________________
    ____
14. Do you smoke? ☐ Yes ☐ No
15. Do you suffer from any type of allergies? ☐ Yes ☐ No If yes: ______________________________
16. Have you had any surgery? ☐ Yes ☐ No If yes: ______________________________________
    ____
17. Women: Are you pregnant? ☐ Yes ☐ No ☐ Not sure Patient Initials ________________

Family History

	Diabetes	Heart	Kidney	Cancer	Back	Other
Mother						
Father						
Brother(s)						
Sister(s)						

Pain/Symptoms Picture

Mark an X on the picture where you have Pain/Symptoms. Include symptoms of pain, numbness, or tingling.



I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE

______________________________ ______________________

Patient or Legal Guardian Signature Date

CONFIDENTIAL NEW PATIENT QUESTIONAIRE (CONT.)

ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

PRIVATE & GROUP ACCIDENT & HEALTH INSURANCE FOR DUIRECT PAYMENT TO DOCTOR
I hereby instruct and direct the ____ Insurance company to pay by Check made out and mailed to:

Joseph Papalia, DC PLLC
28 Jones Street, Suite 101
East Setauket, NY 11733

For professional or medical expense benefits allowable, and otherwise payable to me under my current Insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above the insurance payment, except in instances where No-Fault or Workers Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collections costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

______________________________ ______________________________
Name of Patient (Please Print) Date

______________________________ ______________________________
Signature of Patient Signature of Guardian (if minor)

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to Joseph Papalia, DC PLLC

for services furnished to me by the provider. I authorize any of medical information about me to release to the

Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services

______________________________ ______________________________
Patient Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

Joseph Papalia D.C PLLC 28 Jones Street, East Setauket- Suite 101 NY 11733 (631)813-1827

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, Including various modes of physical therapy and diagnostic X-rays, on me (or on the patient names below for whom I am legally responsible for) by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future work at this clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and any other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it's content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition (s) for which I seek treatment.

Patient Signature________________________________ Date__________________________

Witness Signature_______________________________ Date__________________________

Consent to evaluate and treat a minor:

I, ______________________ being parent or legal guardian of ___________________________
have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

NOTICE OF PRIVACY FOR:
PATIENT'S PROTECTED HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care
- To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered
- To determine patient's benefits in a health care plan
- Releasing information required by State or Federal Public Health law
- To assist in overcoming a language barrier when caring for a patient
- Business associates providing written assurances for your privacy have been attained
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign-ins logs may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom
- Speak to our privacy officer who is : Dr. Joseph Papalia and can be reached at (631) 813-1827 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law
- Obtain an accounting of disclosures of your protected health information
- To render a complaint to our privacy officer or the Secretary of Heath and Human Services

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

____

Name of Patient (print) Signature of Patient/Legal Representative Date

JOSEPH PAPALIA, D.C. PLLC

28 Jones Street,East Setauket NY 11733(631) 813-1827 Fax (631) 813-1834

GENERAL RELEASE AUTHORIZATION AND CONSENT FOR THE RELEASE OF RECORDS

Know All Men By These Presents:

That I, ____
(print patient's name)

have requested the release of the x-rays, reports, progress notes and diagnostic

findings of ____
(print patient's name)

which are a part of the records of ____,
(name of facility where records are on file)

relating to the treatment of said ____
(condition)

and I hereby acknowledge receipt of these records and films.

____
(Witness)

____
(Patient or legal representative)

____
(Date)