Bender Chiropractic Center, PA

Confidential Patient Data

If you need any assistance completing this form, please ask the receptionist

Today's Date _____

Name _____ Date of Birth _____ Age _____

Address _____ Primary Phone _____

City _____ ST _____ Zip _____ Work Phone _____ Phone _____

☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated

Email _____ Social Security # _____

Referred to this Office by: ☐ Friend/Family Name _____ ☐ Driving By

☐ Social Media/Search Name _____ ☐ Other _____

Occupation _____ Employer _____

Emergency Contact _____ Phone Number _____

Insurance Co _____

Are you covered by more than one insurance? ☐ Yes ☐ No Name _____

Medical History

		Self	M	F	M - mother F- father
☐ Numbness	☐ Dislocated Joints	☐	☐	☐	AIDS
☐ Anemia	☐ Headache	☐	☐	☐	Neck pain
☐ Nervousness	☐ Serious injury	☐	☐	☐	Back pain
☐ Asthma	☐ Reproductive disorders	☐	☐	☐	Arthritis
☐ Hepatitis	☐ Sinus trouble	☐	☐	☐	Poor circulation
☐ Bladder trouble	☐ HIV / ARC	☐	☐	☐	Chest Pain
☐ Bone fracture	☐ Tuberculosis	☐	☐	☐	Diabetes
☐ Cancer	☐ Bowel control loss	☐	☐	☐	Epilepsy
☐ Concussion	☐ Menstrual cramps	☐	☐	☐	Heart Trouble
☐ Convulsions	☐ Venereal disease	☐	☐	☐	High blood pressure
☐ Rheumatism	☐ Muscular dystrophy	☐	☐	☐	Kidney disorder
☐ Indigestion	☐ German measles	☐	☐	☐	Multiple sclerosis

☐ Yes ☐ No Have you been treated by a physician for any health condition in the last year? Last Physical Exam _____

Describe Condition _____

Accident History

☐ Job ☐ Auto ☐ Other 1 _____ Date _____

☐ Job ☐ Auto ☐ Other 2 _____ Date _____

☐ Job ☐ Auto ☐ Other 3 _____ Date _____

Surgical History

1 _____ Date _____

2 _____ Date _____

3 _____ Date _____

4 _____ Date _____

Ever been gunshot? ☐ Yes ☐ No Any metal implants ☐ Yes ☐ No

Please Describe Present Major Complaints

Rate on a scale of 1 - 10
10 being worst imaginable

1 _____ Rate _____

2 _____ Rate _____

3 _____ Rate _____

4 _____ Rate _____

Symptoms are worse in ☐ Morning ☐ Afternoon ☐ Night

When did your symptoms start? _____

How did your symptoms start? _____

How long has symptoms persisted? _____

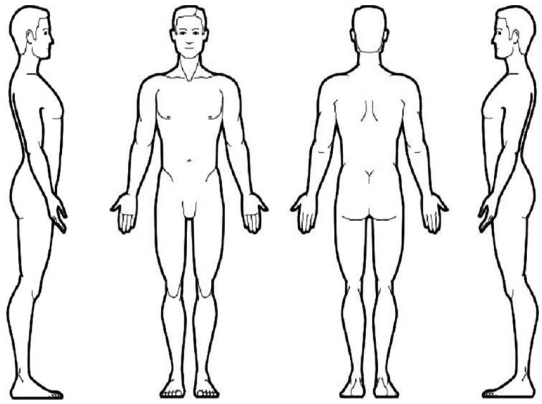
Length of Symptoms ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Cause of Symptoms ☐ Job Related ☐ Auto Accident ☐ Accident ☐ Illness
☐ Gradual Onset ☐ Unknown ☐ Other

Describe the Nature of Your Symptoms

☐ Sharp ☐ Shooting
☐ Dull Ache ☐ Burning
☐ Numb ☐ Tingling

Indicate where you have pain or other symptoms



How are Your Symptoms Changing?

☐ Getting Better
☐ Not Changing
☐ Getting Worse

How much do your symptoms Interfere with your daily life?

☐ Not at All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ A Lot

How much do your symptoms Interfere with your social life?

☐ Not at All ☐ A Little Bit ☐ Moderately ☐ Quite a Bit ☐ A Lot

In general would you say your overall health is right now

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you had these symptoms before? ☐ Yes ☐ No How long ago? _____

Have you seen any other doctor for these symptoms? ☐ Yes ☐ No

If Yes, where? _____

Are you allergic to any medications? ☐ Yes ☐ No Are you taking any medications? ☐ Yes ☐ No

Please indicate on medication/allergy form

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period _____

What activities aggravate your condition?

☐ Bending ☐ Reaching ☐ Sitting ☐ Lifting ☐ Walking ☐ Straining at Stool
☐ Sneezing ☐ Lying Down ☐ Standing ☐ Coughing ☐ Turning Head

What activities relieve your condition?

☐ Bending ☐ Reaching ☐ Sitting ☐ Lifting ☐ Walking
☐ Turning Head ☐ Lying Down ☐ Standing

Name _____

Please check any additional symptoms you may be experiencing

☐ Blurred Vision	☐ Fainting	☐ Stiff Neck	☐ Concentration loss / confusion
☐ Dizziness	☐ Headaches	☐ Fatigue	☐ Depression / weeping spells
☐ Buzzing in ears	☐ Loss of taste	☐ Insomnia	☐ Head seems too heavy
☐ Ringing in ears	☐ Constipation	☐ Fever	☐ Pins and needles in arms
☐ Loss of smell	☐ Diarrhea	☐ Upset stomach	☐ Pins and needles in legs
☐ Loss of balance	☐ Cold hands	☐ Sensitivity to light	☐ Numbness in fingers
☐ Muscle jerking	☐ Cold Feet	☐ Face Flushed	☐ Numbness in toes
☐ Shortness of breath	☐ Cold sweats		☐ Low resistance to colds

Smoking Status

☐ Current, every day ☐ Current, sometimes ☐ Former ☐ Never ☐ Other

Race

☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Pacific Islander

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language _____

HIPPA - Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years. Practice reminders, birthday greetings and promotions will be made by phone, E-mail, and/or mail. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

List the names of people to whom you authorize the release PHI. _____

Patient's Signature _____ Date _____

I hereby authorize Bender Chiropractic Center, PA and staff to administer treatment as deemed necessary to my minor child.

Signature of guardian _____ Name of guardian _____

Lifetime Authorization

I request that payment of authorized **MEDICARE, INSURANCE, WORKER'S COMPENSATION BENEFITS** be made to either me or on my behalf for any services rendered to by Bender Chiropractic Center, PA.

I authorize any holder of medical or other information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agent. Any information needed to determine these benefits for related services.

Patient's Signature _____ Date _____

Guarantee of Payment

In order to induce DR. KIMBERLY J. BENDER and BENDER CHIROPRACTIC CENTER, PA to provide you with Chiropractic services, examinations, treatment and medical-legal correspondence and in consideration of such, I (we), the undersigned, hereby individually, jointly and severally agree and unconditionally promise, to the extent insurance benefits or coverage is unavailable, to pay the full costs and expenses of x-rays, testing examinations, laboratory work, therapy, treatments, consultations, and medical/legal reports, upon such services being rendered, together with interest accrued of 1.5% per month on the unpaid balance, reasonable attorney fees, costs and expenses of billing and collection and litigation if necessary.

Patient's Signature _____ Date _____

Medicines and Allergies

List any known medication allergies or reactions ☐ NKDA

List all current medications and dosages ☐ None

HIPAA Compliant Authorization for Release of Patient Information
Pursuant to 45 CFR 164.508

Section I - Patient Information

Name _____

Address _____

City _____ ST _____ Zip _____

Phone _____ Date of Birth _____

Section II: Authorization for Release of Patient Information: I, or my authorized representative, hereby authorize_____ and their respective employees, agents and subcontractors to disclose my Personal Health Information (PHI) and Insurance Record to: Bender Chiropractic Center, PA, 321 Indian Rocks Road N, Suite C, Belleair Bluffs, FL 33770, (727)-559-7881

Section III - Specific Information to be Released:

☐ Please release my Medical Record from _____ to _____.

☐ Please release my entire Medical Record, including patient histories, office notes (excluding psychotherapy notes, test results, radiology studies, films, referrals, consults, billing records, insurance records sent to Freedom Health by health care providers.

☐ Other: (please explain) _____

_____

Reason for release of information:

☐ At the request of the individual

☐ Other:

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:
Date or event on which this authorization will expire: _____.
If an authorized representative is making this request, please provide your information below and attach certifying documentation of your status as the authorized representative, such as a Power of Attorney or Guardianship papers.

_____ _____

Signature of Member or Authorized Representative Date

Section IV: I understand that Section 460.413 (1) (m), Florida Statutes, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages. The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication. The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.