Patient Information

Name: ______________________________ DOB: __________ SS#: __________________ M/F

Address: ____

Phone: _______________ Cell: _______________ Email: ________________________________

Occupation: _______________________________Employer: ___________________________

HEALTH INSURANCE INFORMATION:

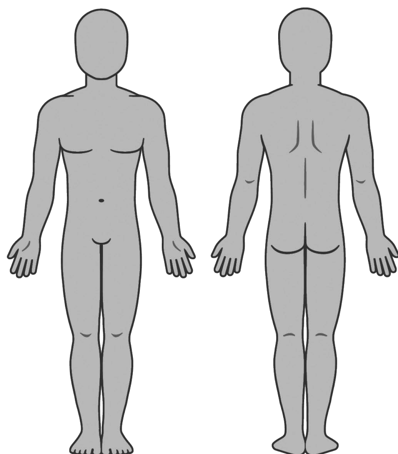
Insurance Co: ____

Insured: ______________________________ Patient Relationship: ______________________

ID #: __________________________________ Group #: ________________________________

Why You Are Here

Chief Complaint: __________________________When did it begin? _________________



Please mark with an X areas of pain on image.

Circle all that apply below:

DULL ACHING SHARP SHOOTING BURNING THROBBING DEEP NAGGING STABBING

Other:_______________________________________

Grade Intensity/Severity: 0= none 10 = worst

0 1 2 3 4 5 6 7 8 9 10

Does the pain radiate, travel or shoot into any areas of the body? Y ___ N ____

If yes, describe: ____

On image above, circle areas with numbness or tingling.

Frequency (circle one): Constant Intermittent How long does it last? _________________

Please list previous injuries/trauma: ____

Have you ever broken a bone? Y ___ N ___ If yes, which one? __________________________

Allergies: ____

Female Patients: Date of last menstrual period? _____ Could you be pregnant? Y ___ N ___

Current Health Conditions: ____

List any medications you are currently taking: Continue on back if needed (please check if using back) ________

____

Medication Name **Dosage** **Frequency**

____

Medication Name **Dosage** **Frequency**

____

List any surgeries you have had: Continue on back if needed (please check if using back) _______

Procedure: ____ **Date:** ______________________

Procedure: ____ **Date:** ______________________

FAMILY HEALTH HISTORY

Mother: Alive: Y N If N: Date of death: ________Current Age/ Age at death: ______

Cause of death: ___________ Health/Medical conditions:_______________________________

Father: Alive: Y N If N: Date of death: ________Current Age/ Age at death: ______

Cause of death: ___________ Health/Medical conditions:_______________________________

Sibling #1 : Alive: Y N If N: Date of death: ________Current Age/ Age at death: ______

Cause of death: ___________ Health/Medical conditions:_______________________________

Sibling #2 : Alive: Y N If N: Date of death: ________Current Age/ Age at death: ______

Cause of death: ___________ Health/Medical conditions:_______________________________

Continue on back if needed : (please check if using back) _______

Social/Occupational History

Education: (circle) High School Some College College Graduate Post Graduate

Job Description: ____

Work Schedule: ____

Recreational Activities: ____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this medical office to provide me with chiropractic care in accordance with the state's statutes.

Signature: ____**Date:** __________

Parent/Guardian: ____ **Date:** _________

Dr. Signature: ____**Date:** _________

2500 S Kanner Hwy Suite 3, Stuart, FL 34994

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic x-rays on myself by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

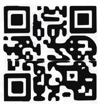
I further understand that such chiropractic services may be performed by the Advanced Wellness associate and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office.

I understand that results are not guaranteed. I also understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks of treatment including but not limited to fractures, disc injuries, strikes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I was to rely upon the physician to exercise judgement during the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment plan recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

PRINT PATIENT NAME: ____

PATIENT SIGNATURE: _______________________________________ **Date:** _________________



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. *DIAGNOSIS OR NATURE OF ILLNESS OR INJURY* Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

RECORDS RELEASE AUTHORZATION

DOCTOR/HOSPITAL: ____

PHONE # ____

FAX # ____

I HERBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

Advanced Wellness Solutions

2500 S Kanner Hwy Suite 3,

Stuart, FL 34994

P: 855-509-5400 (F): 321-373-2062

PLEASE FAX ANY MEDICAL RECORDS AND/ OR XRAY

REPORT FOR DATE OF ACCIDENT: ________________

DOCTOR WAITING

THANK YOU IN ADVANCE AND REQUEST OF MY MEDICAL RECORDS TO:

______________________________ ______________

PATIENT'S SIGNATURE DATE

______________________________ ______________

PATIENT'S NAME (PLEASE PRINT) D.O.B.

______________________________ ______________

IF PATIENT IS A MINOR SIGNATURE OF PARENT OR LEGAL GAURDIAN RELATIONSHIP TO PATIENT

______________________________ ______________

WITNESS TO THE ABOVE SIGNATURE PLEASE PRINT NAME