DATE: ____________

Patient Name: ____________

Patient Address: ____________

____

Date of Birth: ____________ Age: ____________

Email: ____________ Phone: ____________

Married ______ Single ______ Widowed ______

Separated ______ Divorced ______ Minor ______

Social Security # ____________

Employer: ____________

Employer Phone #: ____________

Spouse/Significant other name: ____________

Primary Care Physician: ____________

Primary Care Phone Number: ____________

In Case of Emergency Contact: ____________

Phone Number: ____________

Who referred you to this office ____________

Health Insurance: ____________

Phone Number: ____________

ID #: ____________ Group# ____________

If accident related/auto carrier ____________

Claim# ____________

Date of Accident: ____________

Auto carrier phone number: ____________

Do you have an attorney representing you? ____________

Name: ____________

Number: ____________

Reason for Visit: ____________

When did symptoms appear: ____________

Major complaint: ____________

____

Do you have any numbness or tingling in your extremities: ____________ *Where:* ____________

Have you ever had this problem before: ____________

Have you had any accidents or falls that might have caused this problem? ____________

Have you been in an auto accident in the past year ? ______ In the past 5 years? ______ Ever? ______

Where you seen in the hospital? ____________

Where and when ____________

Have you seen another health care provider for this condition? ______ Where? ____________

Phone #: ____________

Have you had an MRI, NCV, EKG, CAT scan or any other testing done? ____________

Where? ____________

Have you tried any home remedies and if so what were they are what were the results of those home remedies? ____________

Have you been seen by a chiropractor in the past? ______

When was last adustment? ____________

Chiropractor's name and number: ____________

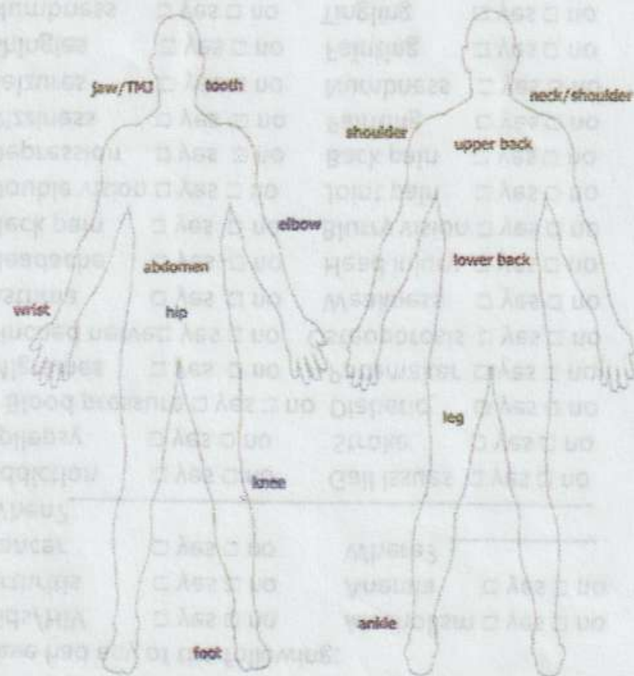
____

Have you had any adverse reactions to chiropractic?

____

If you are in pain please mark in the diagram below exactly where that pain is with an XXXXXX

If you have tingling or numbness mark with an SSSSS



Rate your pain on a scale of 0 to 10 with 10 being severe and 0 being no pain ____________

Type of pain you are experiencing:

Sharp ______ *Dull* ______ *Throbbing* ______

Tingling ______ Burning ______ Stiffness ______

Aching ______ Swelling ______ Numbness ______

Cramps ______ Shooting ______ Other ______

How often do you have this pain? ____________

Is it constand 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 ______ Lifting ______ Laying down ______

Are you pregnant? ______ Trying to conceive? ______

Do you have metal in your body? ____________

Are you claustphobic? ____________

Do you smoke? ______ Date quit ______

Do you drink alcohol? ______ How often ______

Caffeine? ______ How often ______

High stress level? ______ Reason ______

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

Aids/HIV	□ yes □ no	Alcoholism	□ yes □ no
Arthritis	□ yes □ no	Anemia	□ yes □ no
Cancer	□ yes □ no	Where?	________

When?______________________________

Addiction	□ yes □ no	Gail issues	□ yes □ no
Epilepsy	□ yes □ no	Stroke	□ yes □ no
^ Blood pressure	□ yes □ no	Diabetic	□ yes □ no
Migraines	□ yes □ no	Pacemaker	□ yes □ no
Pinched nerve	□ yes □ no	Osteoporosis	□ yes □ no
Asthma	□ yes □ no	Weakness	□ yes □ no
Headache	□ yes □ no	Head injury	□ yes □ no
Neck pain	□ yes □ no	Blurry vision	□ yes □ no
Double vision	□ yes □ no	Joint pain	□ yes □ no
Depression	□ yes □ no	Back pain	□ yes □ no
Dizziness	□ yes □ no	Fainting	□ yes □ no
Seizures	□ yes □ no	Numbness	□ yes □ no
Shingles	□ yes □ no	Fainting	□ yes □ no
Numbness	□ yes □ no	Tingling	□ yes □ no
Back pain	□ yes □ no	Leg cramping	□ yes □ no
Chest tightness	□ yes □no	Palpatations	□ yes □ no
Confusion	□yes □ no		
Concussion	□ yes □no	When	________

Loss of bowel or bladder control □ yes □ no

Trauma □yes □ no When__________

Disk herniation □yes □ no What levels__________

Disk bulge □ yes □ no What levels __________

MRI done where? ______________________

Name of your primary care physican______________

Phone# or address ______________________

Date of last visit with primary______________

Are you treating with any other doctor for any reason?

□ yes □ no Who______________________

For______________________________

In order to provide you with care in this office it is very important that you disclose any health concerns you may have. At times in order to coordinate our dcare we will need to confer with other physicians with regard to your health. By signing this form you are acknowledging that and giving this office consent to allow us to contact and exchange health information with other doctors. I attest that the information on this form is correct and accurate and i will not hold Dr Byrne/Byrne Chiropractic liable for any ommissions or inaccuracies contained within the confines of this questionaire.

Patient signature______________ date______

Please list all surgeries and the approx dates of those surgeries:

Surgery______________ date__________

Surgery______________ date__________

Surgery______________ date__________

Surgery______________ date__________

Surgery______________ date__________

Medications, vitamins, mineral and herbs you take:

____

____

____

____

Broken bones and approx dates:

____

____

____

____

Any other information you want to share with the doctor______________________

____

____

____

____

THE PATIENT'S BILL OF RIGHTS

THE PATIENT'S BILL OF RIGHTS ARE POSTED IN THE THERAPY SUITE AND AVAILABLE FOR REVIEW IN THIS PATIENT PACKET. I AM ACKNOWLEDING THAT I HAVE RECEIVED OR VIEWED A COPY OF THE PATIENT'S BILL OF RIGHTS. PATIENT SIGNATURE

Sign____________________date:_____________

ACKNOWLEDGE OF RECEIPT OF 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 WIL BE PLACED IN MY PATIENT CHART AND WILL BE MAINTAINED FOR SIX YEARS. A COPY OF THE PRIVACY PRACTICES IS AVAILABLE AT THE FRONT DESK.

Sign____________________date:_____________

CONSENT FOR TREATMENT OF A MINOR

I, AS THE PARENT OR LEGAL GUARDIAN OF THE PATIENT, DO HERBY GIVE MY CONSENT AND AUTHORIZE TREATMENT FOR MY DAUGHTER/SON PARENT OR GUARDIAN'S

NAME________________ DATE: __________

SIGNATURE________________________________

CONSENT TO TEXT MESSAGES FOR APPOINTMENT REMINDERS AND HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via text message to remind them of an appointment or healthcare issues. I consent to receiving these texts

PATIENT SIGNATURE ________________ date________

OFFICE POLICIES AND PROCEDURES AGREEMENT, FINANCIAL ARRANGEMENTS AND POLICIES: I understand and agree that health and accident policies are an arrangement between and insurance carrier and me. This office will prepare necessary billing forms to assist in making collection from the insurance company and any amount paid directly to this office will be credited to my account. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that payment for my portion of the charges is due at the time that services are rendered. My portion would include any deductible, copayment, or any products or services not covered by my insurance. Patients are ultimately fully responsible for products purchased and services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, ultimately it is the patient's responsibility to determine benefit and authorization information before services are rendered. Verification of benefits is not a guarantee of payment. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of products and service is not authorized or covered by their insurance company. Your signature below will give power of attorney to endorse checks made to Byrne Chiropractic to be credited to your account.

RETURN POLICY: We do not accept returns on any item purchased thru this office unless that item is proven defective. We will not take any returns on a special ordered item.

CANCELLATION POLICY: Cancelations of appointment/no shows: When you do not show up for a scheduled appointment it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 in advance to cancel your appointment. If for any reason you need to cancel an appointment, please notify are office as soon as possible. On your second no show occurrence, there will be a $25.00 charge to your account. After three consecutive no show occurrences, the practice may elect to terminate your relationship with you. INITIAL_______

INFORMED CONSENT TO CHIROPRACTIC CARE: I request and consent to the performance of chiropractic examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself or on the patient named below for whom I am legally responsible by any of the treating doctors of chiropractic on staff and any licensed chiropractor deemed appropriate by the office as well as any and all staff members. I understand that results of treatment are not guaranteed. I have been informed and I understand that in the practice of medicine, in this case chiropractic, there are risks associated with treatment although rare, including but not limited to fracture, disc injuries, strokes, dislocations, strains and worsening of symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complication s of my case, and I wish to rely on the doctor to exercise judgment during the course of the procedure. Which the doctor feels at the time based on the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

RECORDS RELEASE AUTHORIZATION: I hereby grant permission for Byrne Chiropractic to release any information pertaining to diagnosis and treatment of myself and care in this office to other offices, to my primary care physician, or to any other physician or therapist with who I am currently or previously under care.

Initial____________

Patient name_________________________

Signature_________________________date___

Mother/father/legal guardian's name__________

Signature_________________________date______

Relationship to patient_________________________

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Section 381.026 Florida Statues addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and wellbeing of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care provider or health care facility recognize you are receiving medical care and that you respect the health care providers or health care facility's right to expect certain behavior on the part of the patient. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to:

**Be treated with courtesy and respect, with appreciation of his or her dignity and with protection of privacy.
**Receive a prompt and reasonable response to questions and requests.
**Know who is providing medical services and who is responsible for his or her care.
**Know what patient support services are available, including if an interpreter is available if the patient does not speak English

** Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.
**Express complaints regarding any violations of his or her rights.

A patient is responsible for:

**Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications and any other information about his or her health. **Reporting unexpected changes in his or her condition to the health care provider.
**Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.
** Following the treatment plan recommended by the health care provider.
** Keeping appointments and when unable to do so notifying the health care provider or facility.

** His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.
** Making sure financial responsibilities are carried out.

**Know what rules and regulations apply to his or her conduct.
**Be given by the health care provider information such as diagnosis, planned course of treatment, alternative, risks and prognosis.
**Refuse any treatment, except as otherwise provided by law.
**Be given full information and necessary counseling on the availability of known financial resources for care.
**Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
** Receive prior to treatment, a reasonable estimate of charges for medical care.
**Receive a copy of an understandable itemized bill and if requested to have the charges explained.
**Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.
**Receive treatment for any emergence medical condition that will deteriorate from failure to provide treatment.

** Making sure financial responsibilities are carried out.
** Following health care facility conduct rules and regulations.

In accordance with all stated above, I hereby understand and agree to the above stated office policies.

PRINT PATIENT'S
NAME________________
SIGNATURE__________Date______
LEGAL GUARDIAN
NAME:________________
LEGAL GUARDIAN
SIGNATURE:__________Date______
RELATIONSHIP TO
PATIENT:________________Date:______