

# 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 <input type="checkbox"/> M <input type="checkbox"/> F SOC. SEC. # _____ - _____ - _____
MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W SPUOSE NAME: _____
TYPE OF INS.? <input type="checkbox"/> AUTO <input type="checkbox"/> WORKER'S COMP <input type="checkbox"/> PERSONAL INJ <input type="checkbox"/> PRIVATE HEALTH <input type="checkbox"/> MEDICARE <input type="checkbox"/> 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: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> _____	
4. NAME OS INSURANCE CO. _____	
5. ADDRESS: _____	
6. INSURANCE PHONE # (____) _____	7. POLICY # _____
<b>SECONDARY INSURANCE</b>	
8. INSURED'S NAME _____	9. SS# ____/____/____
10. NAME OF INSURANCE CO. _____	
11. ADDRESS: _____	
12. INSURANCE PHONE # (____) _____	13.POLICY # _____

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

## PATIENT HEALTH INFORMATION

1. MAJOR COMPLAINT(S) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 2. CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past		Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Middle Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, Visual Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arms or Elbows	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness of Joints	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (Lung Disorder)
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ear noises)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	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 than 50% of workday  Light manual labor  
 Other \_\_\_\_\_

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

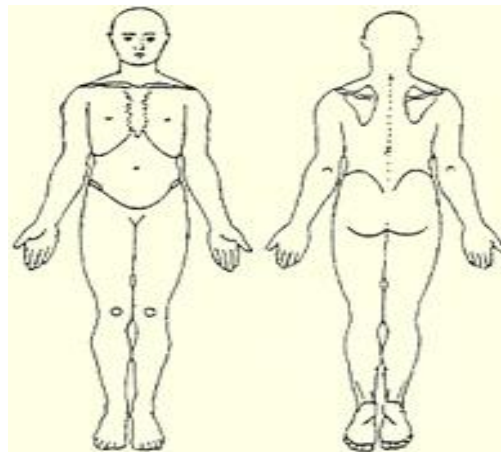
11. Are your complaints affecting your ability to work or otherwise be active?  
 No effect     Some physical restrictions (able to perform light duty housework and household tasks)  
 Need limited assistance with everyday tasks                       Need assistance often  
 Have a significant inability 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 QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE**

\_\_\_\_\_  
 Patient or Legal Guardian Signature

\_\_\_\_\_  
 Date

# CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (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  
7 Mark Tree Road  
Centereach, NY 11720

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, 7 Mark Tree Rd, Centereach, NY 11720 (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 Health 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.

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Name of Patient (print)

Signature of Patient/Legal Representative

Date