Advanced SPINE REHAB & Athletics

Patient Information:

Full Name: _____ Sex: M F

Date of Birth: _____ Social Security #: _____ Marital Status: S M D W

Address: _____ City, State, Zip _____

Cell Phone: _____ Home or Work Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Health Insurance Information:

Primary Insurance: _____
Member ID #: _____ Group #: _____ Relationship to Insured: _____
Policyholder Name: _____ DOB: _____ SSN: _____

Secondary Insurance: _____
Member ID #: _____ Group #: _____ Relationship to Insured: _____
Policyholder Name: _____ DOB: _____ SSN: _____

Appointment Reminders:
As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like automatic reminders? □ Email □ Text - Cell Phone Provider: _____

Accident Information:
Is this visit due to an accident? □ Yes □ No Type? □ Auto □ Work □ Other Date of Accident: _____
Has the accident been reported? □ Yes □ No To Whom? _____

Whom may we thank for referring you to our office? _____

Patient/Guardian Signature: _____ **Date:** _____

Treatment of a Minor Child:
I authorize Advanced Spine Rehab and Athletics to examine and provide necessary treatment and adjustments to my minor child _____.

Parent/Guardian Signature _____ **Date:** _____

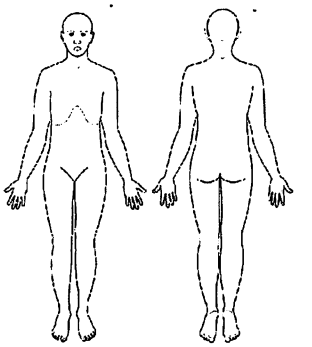
Patient Condition and Health History

Reason for your visit:

□ Neck Pain/Stiffness	□ Jaw Problems	□ Headaches/Migraines	□ Dizziness
□ Mid Back Pain/Stiffness	□ Shoulder Pain	□ Elbow Pain	□ Wrist/Hand Pain
□ Low Back Pain/Stiffness	□ Hip Pain	□ Knee Pain	□ Ankle/Foot Pain
□ Pins/Needles in Arms	□ Pins/Needles in Legs		

□ Other _____

Mark an "X" on the picture where you are experiencing symptoms:



When did your symptoms appear? _____

Is your condition/Symptoms: □ Getting Worse □ Getting Better □ Staying the Same

Do the symptoms interfere with: □ Daily Routine □ Recreation □ Sleep □ Work

What treatment have you already received for your condition? □ Physical Therapy

□ Medications □ Chiropractic □ Surgery □ Other: _____

Have you had: □ X-Rays □ MRI/CT Scan □ Other: _____ When? _____

Are you currently Pregnant? □ Yes □ No If yes, when is your due date? _____

Dominant Hand? □ Right □ Left

Are you currently on any blood thinners? □ Yes □ No

Do your work activities mostly involve: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Please check to indicate if you have ever had any of the following:

□ Aids/HIV	□ Chest Pain	□ Heart Disease	□ Mononucleosis	□ Sleeping Difficulties
□ Alcoholism	□ Chicken Pox	□ Hepatitis	□ Multiple Sclerosis	□ Stomach Problems
□ Allergies/Allergy Shots	□ Cold Feet	□ Hernia	□ Mumps	□ Stroke
□ Anemia	□ Constipation	□ Herniated Disc	□ Nervousness	□ Sudden Weight Loss
□ Anorexia	□ Depression	□ Herpes	□ Night Pain	□ Thyroid Disorder
□ Appendicitis	□ Diabetes	□ High Blood Pressure	□ Osteoporosis	□ Tonsillitis
□ Arthritis	□ Eczema	□ High Cholesterol	□ Parkinson's Disease	□ Tuberculosis
□ Asthma	□ Emphysema	□ Kidney Disease	□ Pinched Nerve	□ Tumors/Growths
□ Bleeding Disorders	□ Epilepsy	□ Light Bothers Eyes	□ Pneumonia	□ Typhoid Fever
□ Blurred Vision	□ Fainting	□ Liver Disease	□ Polio	□ Ulcers
□ Bowel/Bladder Changes	□ Fatigue	□ Loss of Memory	□ Prostate Problems	□ Unintentional Weight Loss
□ Breast Lump	□ Fractures	□ Loss of Smell	□ Prosthesis	□ Vaginal Infections
□ Bronchitis	□ Glaucoma/Cataracts	□ Loss of Taste	□ Rheumatoid Arthritis	□ Venereal Disease
□ Bulimia	□ Goiter	□ Measles	□ Rheumatic Fever	□ Other: _____
□ Cancer	□ Gonorrhea	□ Migraines	□ Scarlet Fever	_____
□ Chemical Dependency	□ Gout	□ Miscarriage	□ Shortness of Breath	_____

Contraindications: **Certain procedures should be avoided if patients have certain conditions. Please answer the following:**

Do you have a Pacemaker? □ Yes □ No

Do you suffer from blood clots? □ Yes □ No

Do you have a knee or hip replacement? □ Yes □ No

Do you have a local or systemic infection? □ Yes □ No

Family History (Indicate which family member and type):

□ Heart Disease _____

□ Diabetes _____

□ Cancer _____

□ Arthritis _____

□ Other _____

Medications/Supplements:

_____

_____

_____

Surgeries/Hospitalizations:

_____

_____

_____

Allergies:

_____

_____

_____

Exercise

□ None Activities: _____

□ Moderate _____

□ Daily _____

□ Heavy _____

Habits

□ Smoking Packs per Day _____

□ Alcohol Drinks per Week _____

□ Caffeine Cups per Day _____

□ Energy Drinks Drinks per Day _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient or Guardian Signature: _____ **Date:** _____

Consent to Treatment

I understand that Advanced Spine Rehab and Athletics will attempt to diagnose and treat any symptoms I am experiencing through diagnostic testing, chiropractic care, active/passive rehabilitation, physical therapy and/or massage therapy. I will be referred to an appropriate physician should there be a condition or symptom present that is out of the Doctor's scope of practice. I am also aware that any treatment provided is meant to help my condition, but in certain cases due to underlying physical defects, pathologies or deformities there may be an increase in the risk for injury. I am responsible to inform the doctor of any conditions (illnesses, deformities, etc.). I also clearly understand that if I do not follow the Doctor's specific recommendations that I will not receive the full benefit from the treatment and/or program.

Financial Policy

I understand that I am financially responsible and agree to ensure full payment for any and all fees incurred for any services/treatment provided to me regardless of any health insurance coverage that may provide payment on my behalf. Payment is due at the time of service unless other payment arrangements have been agreed upon by all parties. If I terminate my care prematurely, all fees incurred are immediately due and payable at that time and any discounts will not apply. I am aware that there will be a $20 fee charged for any returned checks.
*Insurance Patients: I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself. If this office chooses to bill any service to my health insurance carrier, it is strictly as a convenience to me. The office will provide any necessary reports or required information to my insurance carrier, but I am responsible for any unpaid balances due to denied claims.

Insurance Authorization and Assignment

I authorize Advanced Spine Rehab and Athletics to release any medical information necessary to process any insurance claims. Upon receipt of written request, I authorize any fiduciary or plan administrator, my attorney or insurer to release any and all insurance policies, settlement information or plan documents to Advanced Spine Rehab and Athletics and its representatives for the purpose of medical benefits and reimbursement. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I authorize the assignment of all insurance benefits to be directed to the Doctor and/or Physician for all services rendered.

I certify that I have read and fully understand this assignment and authorize this assignment to remain in effect until revoked by me in writing. A copy of this assignment is as valid as the original.

Name of Guarantor (person responsible for guaranteeing payment of all services) _____

Patient or Guardian Signature: _____ **Date:** _____

X-Ray Consent

I understand that the Doctor may recommend x-rays to accurately diagnose and analyze my condition. By signing below, I do hereby consent and will allow Advanced Spine Rehab and Athletics to take x-rays of my spine and/or extremities.

Females Only: I also hereby declare that to my knowledge, I am not pregnant. _____ (initial)

Patient or Guardian Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby confirm that I have received a copy of Dr. Gina Infantino, D.C., M.S. and Dr. Christopher McDonough, D.C., M.S.'s **Notice of Privacy Practices**. I understand that it is my responsibility to familiarize myself with the contents of this Notice.

Patient or Guardian Signature: _____ **Date:** _____