

WELCOME TO MARVIN FAMILY CHIROPRACTIC, PC

Date: _____ Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Birthdate: _____

Home phone: _____ Employer phone: _____ Cell: _____

EMAIL address: _____ (your email will not be shared with anyone)

Social Security #: _____ How did you hear about our office: _____

YOUR Employer: _____ Address: _____

Occupation: _____ MARRIED DIVORCED SINGLE WIDOWED

Spouse's name: _____ Do you have any kids? Y or N how many? _____

SPOUSE'S EMPLOYER: _____

Emergency contact info: Name _____ Phone: _____ Relation: _____

Have you ever been to a Chiropractor before? Y N if yes whom? _____ date of last visit: _____

Have you been a motor vehicle accident in the past? Y or N work related Y N

Who is your primary care physician: _____ last seen date: _____ reason: _____

Have you had recent xrays? MRI? CT? When, where and what part of your body? _____

REASON FOR YOUR VISIT

Is it work related? Y or N Is it related to a Motor Vehicle Accident? Y or N

PAIN IN THE(circle those that apply) NECK UPPER BACK MID BACK LOWER BACK BUTTOCKS
THIGH LEG FOOT SHOULDER R/L ARM FOREARM HAND JAW FACE HEAD

other: _____

When did your discomfort begin: _____ Was the onset of pain: IMMEDIATE or GRADUAL (circle one)

Why did the discomfort start? _____

Is your discomfort: IMPROVING WORSENING STAYING THE SAME (circle one)

Describe your pain (using 0 to 10 with 0 no pain & 10 the worst): _____ (worst) _____ (best)

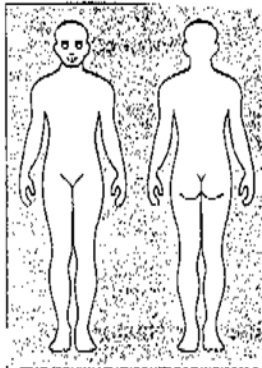
Is your discomfort CONSTANT (100%) FREQUENT(75-100%) INTERMITTENT(25-50%) OCCASIONAL(0-25%)

The following are affected by your discomfort (circle all that apply): sleep work sitting standing bending
lifting walking twisting sports carrying getting up lifting your arms or legs

Is your discomfort worse in the AM PM varying through out the day same all day

What makes you feel better? Ice Heat Sitting Standing Laying down Medication Sleep

USE THE DIAGRAM TO MARK WHERE IT HURTS:



PLEASE CONTINUE TO PAGE 2

NAME: _____

Marvin Family Chiropractic PC

HEALTH HISTORY: CIRCLE THE CONDITIONS YOU HAVE:

Height: _____ Weight: _____ lbs

- Headaches/Migraine/Sinus/Tension
- Neck pain
- Upper back pain
- Mid back pain
- Lower back pain
- Buttock pain
- Hip pain
- Thigh pain
- Knee pain
- Leg pain
- Ankle pain
- Foot pain
- Shoulder pain
- Arm pain
- Forearm pain
- Wrist pain
- Hand pain
- Jaw pain
- Chest pain
- Abdominal pain
- High blood pressure
- High cholesterol
- Arthritis: where _____
- Type I Diabetes (insulin)
- Type II Diabetes (NON insulin)
- Hypothyroidism
- Hyperthyroidism
- Osteoporosis
- Osteopenia
- Asthma
- Allergies
- Sensitive skin
- Gout
- Cervical/lumbar disc problem
- Shingles
- Rheumatoid arthritis
- Stroke
- Heart attack
- Heart disease
- GI problems
- Cancer: where: _____
- Pregnancy
- Prostate problems
- Parkinson's disease
- Kidney problems/stones
- Alzheimer's disease
- Liver problems
- Eyes issues
- Lung problems
- Hearing issues
- Bladder problems
- Gall bladder problems
- Polio
- Anxiety issues
- Depression
- HIV/AIDS
- Anemia
- Pacemaker
- Defibrillator
- Pain pump
- Eating disorders
- Multiple sclerosis
- Miscarriage when: _____
- Bruise easily
- Fevers Chills Sweats
- Dizziness/Vertigo
- Constipation
- Head trauma
- Cold feet / hands
- Other: _____

Are you currently pregnant? Y N when are you due? _____ If no when was your last menstrual: _____

Surgeries: _____ Broken bones: _____

Previous MVA: Y or N when: _____ Previous work related injuries: Y or N when _____

Is your sleep affected by your discomfort? Y or N Does your pain affect (FALLING) (STAYING) ASLEEP

Do you sleep on your: SIDE STOMACH BACK (circle those that apply) Do use a cervical pillow? Y or N

Exercise: NONE MODERATE DAILY HEAVY WHAT TYPE: CARDIO YOGA PILATES WEIGHTS

Do you smoke? Y or N how much? _____ a day QUIT: how long ago? _____ Do you drink alcohol? Y or N how much? _____ a wk

MEDICATIONS(circle those you are currently taking)

ADVIL / MOTRIN / ALEVE / TYLENOL / ASPIRIN / MUSCLE RELAXERS / PAIN PILLS / BLOOD PRESSURE / BLOOD THINNERS / HIGH CHOLESTEROL / THYROID MED / ANXIETY-DEPRESSION MEDS / OSTEOPOROSIS DIABETIC MEDS / SLEEP AID / ASTHMA MED / BIRTH CONTROL

If you have a list of your medications please give it to our office staff.

What vitamins to your take (circle): Multi Vitamin Vitamin C Joint support formula Calcium B complex other: _____

Are you interested in losing weight? Y or N Do you like massage therapy? Y or N Do you wear foot orthotics? Y or N

INSURANCE INFORMATION

Name of Ins. Company: _____ Policy #: _____

Group #: _____ Name of the Insured: _____ Insured Date of Birth: _____

Name of Insured Employer: _____ City: _____ State: _____

***** FINANCIAL AGREEMENT *****

I hereby request that my insurance company send payment directly to Marvin Family Chiropractic, PC. I understand and agree that my insurance policy is an agreement between my insurance carrier and myself. I understand that Marvin Family Chiropractic, PC will prepare any necessary forms to assist me in making collection from the insurance company and that any amounts paid to this office will be credited to my account upon receipt. Our office does not accept payment from secondary insurance, however we will fill out necessary paperwork to make it easier for you to be reimbursed. I understand that I am responsible for all non covered services. **I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.** I also understand that should I terminate my treatment that any fees outstanding would become *IMMEDIATELY DUE AND PAYABLE*.

I further understand that any fees not paid within a 30 day period will be assessed a \$10 billing fee and 1.5 % monthly interest charge. Should it become necessary for this office to utilize a collection company for payment of services, my account would be subject to a \$50.00 collection fee. Failure to pay any balances more than 30 days old will result in your credit card being charged.

Patient's/Guardian Signature: _____ Date: _____

CREDIT CARD INFORMATION

Card #: _____ Expiration date: _____

Name on card: _____ Name of bank: _____

Patient's/Guardian Signature: _____ Date: _____

CREDIT CARD INFORMATION IS REQUIRED PRIOR TO TREATMENT BEING RENDERED.

PLEASE CONTINUE TO NEXT PAGE

Marvin Family Chiropractic, P.C.
Kenneth R. Marvin D.C., C.C.S.P.
37 East Central Avenue
Pearl River, New York 10965
845-735-4755

Notice of Privacy For: Patient's Protect Health Information

This notice describes how health care information about you may be used and disclosed and how 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 reminder to household members or answering machines.
- Sign-in 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. Kenneth R. Marvin and can be reached at 845-735-4755 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 office or 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.

Name of Patient (PRINT) Signature of Patient/Legal Representative Date

RELEASE OF MEDICAL RECORDS:

I, hereby give authorization for the release my medical records to Marvin Family Chiropractic, PC.

Name of Patient (PRINT) Signature of Patient/Legal Representative Date