INSURANCE QUESTIONNAIRE

-PLEASE ANSWER ALL QUESTIONS COMPLETELY-

PATIENT INFORMATION: **DATE:** _____

Name: _____ SS#: _____

Sex: Male / Female E-mail address: _____

Marital Status: S M D W Are you a minor?: Y / N

Birth Date: ____ / ____ / ____ Age: ____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

EMPLOYMENT INFORMATION:

Employer / Business Name: _____

Phone #: ( ) _____ EXT: _____

Address: _____

Job Title: _____

INSURANCE INFORMATION:

Insurance Company: _____

Policy Number: _____

Name of policyholder: _____

Relationship to Patient: _____

I understand and agree that health insurance policies are an agreement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to my carrier and I may be personally responsible for payment if services are not covered.

Patient Signature: _____ Date: _____

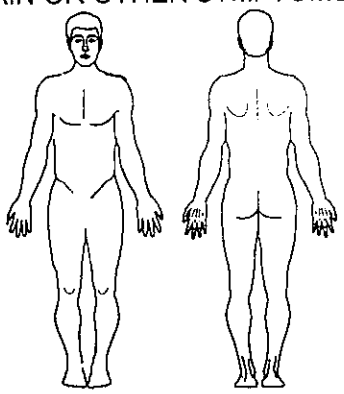
How were you referred to our office? _____

American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
Primary Care Physician Name: _____ PCP Phone: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____
_____
_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Surgeries/Medications: _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

South Shore Chiropractic, P.C.

700 Horseblock Road
Farmingville, NY 11738
Telephone: (631) 732 – 1386
Fax: (631) 732 – 1544

1245 Montauk Highway
Mastic, NY 11950
Telephone: (631) 395 – 8520
Fax: (631) 395 – 8521

sschiropractic@optonline.net

I, _____ fully understand that my Insurance Company, _____, requires a referral from my primary care physician. I agree that I will cooperate in this matter and get the referral within the designated time period; If I do not get the referral for South Shore Chiropractic, P.C. on time I do understand that I will be held responsible for the services rendered to me at the time the referral should have been received.

Signature of Patient: _____

Date of Signature: _____

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1245 Montauk Highway
Mastic, NY 11950
Telephone: (631) 395 – 8520
Fax: (631) 395 – 8521

Date:

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

South Shore Chiropractic, P.C.
700 Horseblock Road
Farmingville, NY 11738

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

South Shore Chiropractic, P.C.
700 Horseblock Road
Farmingville, NY 11738

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____day of _____, 20_____

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder