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? _____

PAIN DRAWING

Name: _____ Todays Date: _____

Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache > > > >
> > > >

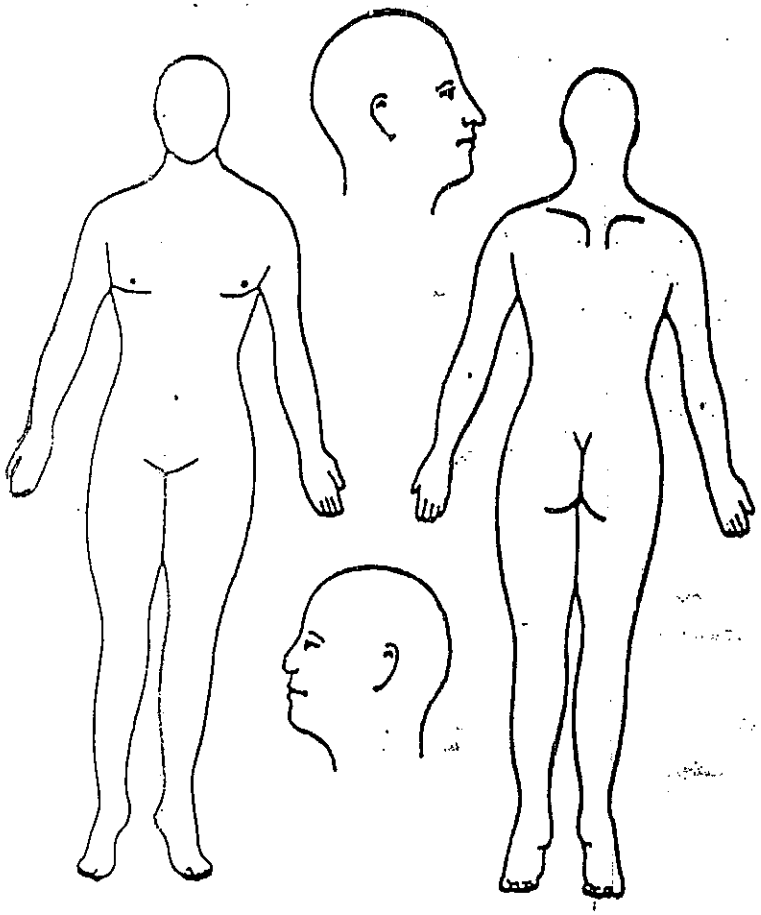
Numbness - - - -
- - - -

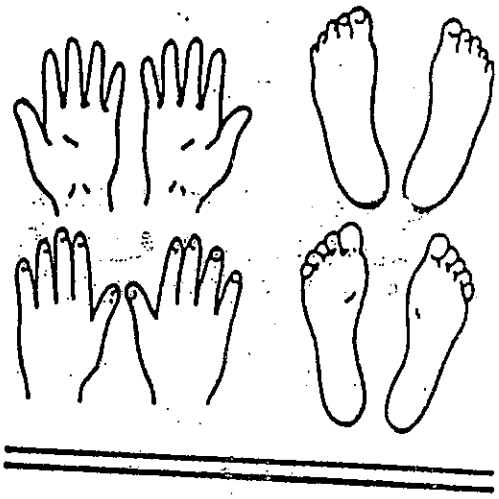
Pins and Needles o o o o
o o o o

Burning x x x x
x x x x

Stabbing / / / /
/ / / /

Throbbing ~ ~ ~ ~
~ ~ ~ ~





SEVERITY OF PAIN

List region of pain and circle severity number. [1 = least, 10 = greatest]

ex. Neck
1 2 3 (4) 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

4. _____
1 2 3 4 5 6 7 8 9 10

5. _____
1 2 3 4 5 6 7 8 9 10

HEALTH QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY:

MUSCULO SKELETAL SYSTEM

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Rupture
___ Broken bones

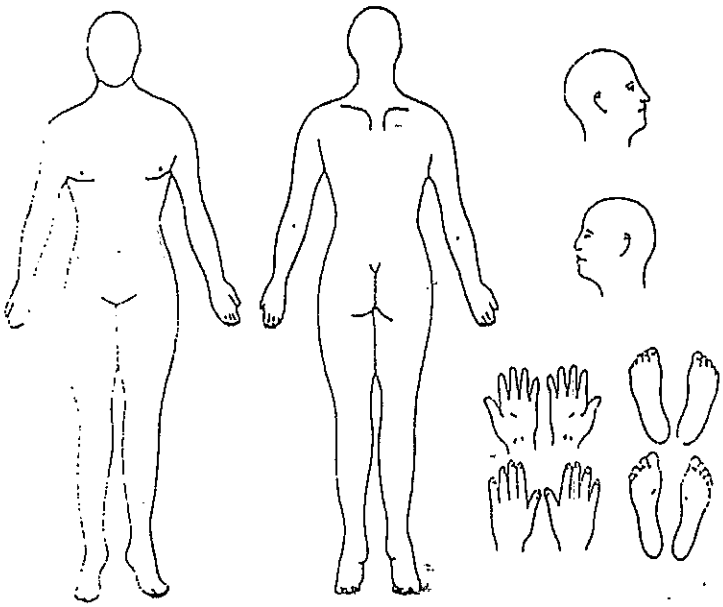
GENITO-URINARY SYSTEM

___ Bladder trouble
___ Excessive urination
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Are you pregnant?
___ Yes ___ No



GASTRO-INTESTINAL SYSTEM

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIO VASCULAR RESPIRATORY SYSTEM

___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYES, EAR, NOSE AND THROAT

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficulty breathing thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

_____
Patient's Signature

**********DO NOT WRITE BELOW THIS LINE**********

_____

_____

_____

_____

_____

_____

Patient Accepted? Yes No Doctor's Signature_____

South Shore Chiropractic, P.C.

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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

Medicare Authorization of Benefits

DATE: _____

Name of Patient: _____

Medicare Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to South Shore Chiropractic, PC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and its agents any information needed to determine these benefits or the benefits payable for related service.

Dated at South Shore Chiropractic this _____ day of _____, 20_____

Patient Signature _____

Witness _____