Dr. David N. Block Family Chiropractor - Patient Information

Name(First, Middle, Last)____Date_________

Address(no PO boxes)____________________________City__________________State_____Zip________

Home phone__________________Work phone___________________ Cell phone___________________

How do you prefer your electronic appointment reminder, email or text? _________________

For text reminders, please list your cell phone carrier (AT&T, Verizon, T-Mobile, Sprint, etc) _____________________

Social Security # __________________ E-mail address____

Age ______Birthdate ______/______/______ Sex M / F Status M S W D No.Children_______

Occupation _________________________Employer _________________________Years Employed_____

Work Address__________________________City____________________State_____ Zip_____________

Spouse's Name_______________Occupation_____________ Employer ____________ S.S.#_________

Primary Insurance Plan Name_____________________________ID#_____________Group#____________

Policy Holder's Name__________________Relationship to policy holder:Spouse___Child___Self___

Policy Holder's Birthdate ___________

Secondary Insurance Plan Name ___________________ ID# ______________ Group #_________

Is your condition due to an auto accident? Yes____No____ If yes, what state? ______

Is your condition work related?Yes__No__ Is your condition related to another accident? Yes__No__

What is your deductible_________________ Was it met? Yes ____ No ____ Unsure ____

If no, it will be paid by Cash______ Check______ Credit Card______ Other_______

Immediate Family under care in this clinic____

I understand that the above patient is a minor and I personally guarantee payment for all charges related to:

*(patient name)*____*Name of guarantor:* ___________________

Signature of

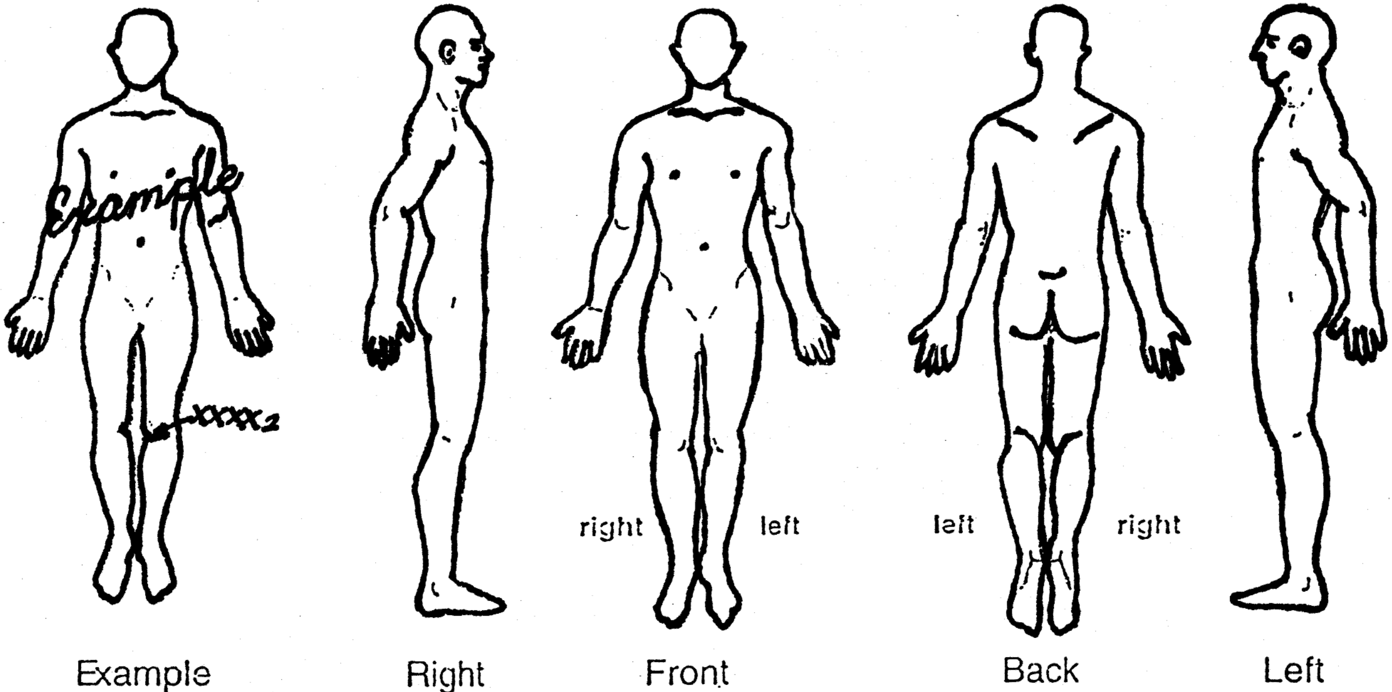
*guarantor:*______________________________________*Date:*___________________________With my

signature below, I authorize the assignment of insurance benefits directly to Dr. David N. Block.

Patient/Guarantor Signature: ____Date:______________

Show Us Where It Hurts:

In the diagram below, please draw an arrow pointing to the area(s) of your pain or condition:



Authorization for Care, Insurance Assignment & Fees **Please read and sign**

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that Dr. David N. Block will prepare any necessary documents to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. David N. Block will be credited to my account on receipt (insurance assignment of benefits). However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment as well as collection manager/attorney's fees of 33.3% and any and all related costs of collection, including filing fees, should such action become necessary. Interest rate on unpaid balances is the greater of 1.65% per month or $5.00 per month and begins from the time an account has been considered delinquent. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I also authorize the doctor to bill any unpaid balance to my credit card if it was used previously in the office to pay for services rendered, to obtain a credit report if deemed necessary and verify my employment should that information be needed in the collection of unpaid balances.

I hereby authorize the doctor to provide for me manual adjustments to my spine and therapy. The patient also agrees that he/she is responsible for all bills incurred at this office including interest on unpaid balances. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

Patient Name____ Date____________________

Patient Signature ____ Date____________________

Guardian/Spouse/or Guarantor's Name Authorizing Care______________________________Date:_________

Guardian/Spouse/or Guarantor's Signature Authorizing Care___________________________Date:__________

CURRENT HEALTH CONDITION: Name ________________________ Date: ____________

- **Please describe your pain or health problem** - including where you feel the pain, how often you feel it, and what you think may have caused it:____
____
____
- **Which best describes your discomfort?** ☐ ache ☐ sharp/stabbing ☐ burning ☐ pins & needles ☐ numbness
- **Rate how much it bothers you - on a scale of 1 (discomfort) to 10 (extreme pain)**________________________
- **What activities/positions/etc. makes it feel worse?**____
- **What makes it feel better?**____
- **Does your current condition ever cause you to be:** ☐ moody ☐ irritable ☐ unpleasant ☐ depressed ☐ angry
- **What is your occupation?**________________________**How does your condition interfere with your work?**

☐ decreased productivity ☐ hard to concentrate ☐ can't work without pain ☐ had to stop working/disabled

- **What activities have you been forced to stop or hesitate doing because of your condition?**

☐ athletic/exercise activities ☐ household work - lifting, etc. ☐ gardening ☐ walking ☐ biking ☐ dancing

☐ running ☐ lovemaking ☐ other (please list):____

- **Check any of the following drugs & treatments you have used unsuccessfully to get rid of this problem:**

  ☐ tylenol ☐ advil ☐ aspirin ☐ aleive ☐ motrin ☐ antacids ☐ sinus medicine ☐ blood pressure pills

  ☐ muscle relaxers ☐ ice ☐ heat ☐ massage ☐ herbal or remedies ☐ ben-gay or other ointments

  ☐ pain medicine injections ☐ prescription pain medicine (please list) :________________________________

  ☐ bed rest ☐ other (please list):____

- **Check off any tests or evaluations you have had for this condition(s):**

☐ x-ray ☐ MRI ☐ CAT scan ☐ bone scan ☐ blood tests ☐ other_________________________________

- **Check off any type of doctors you've consulted for this condition(s):**

☐ general medical physician ☐ orthopedist's ☐ neurologist ☐ rheumatologist ☐ cardiologist's

☐ dermatologist ☐ podiatrist ☐ dentist ☐ pediatrician ☐ psychiatrist ☐ allergist ☐ Ob/Gyn ☐ herbalist

☐gastrointestinal/internal medicine ☐ urologist ☐ oncologist ☐ opthalmologist ☐ pain clinic

☐ lung specialist ☐ ear, nose & throat ☐ sports medicine ☐ physical therapist ☐ osteopath ☐ physiatrist

☐ **other chiropractor(s):** Who?____

How long and often did you go?____________________ When was your last appointment?_________________

PAST HEALTH HISTORY - ***Check any of the following conditions you have ever had:***

☐ Pneumonia ☐ Mumps ☐ Influenza ☐ Rheumatic Fever ☐ Small Pox ☐ Pleurisy ☐ Polio ☐ Chicken Pox
☐ Arthritis ☐ Tuberculosis ☐ Diabetes ☐ Epilepsy ☐ Whooping Cough ☐ Cancer ☐ Mental Disorders
☐ Measles ☐ Thyroid ☐ Eczema ☐ Psoriasis ☐ Tonsillitis ☐ Tested HIV positive

- **Have you ever had any surgery?** ☐ yes ☐ no Type:____
- **Have you ever been hospitalized?** ☐ yes ☐ no Why?____
- **Please list all medications currently taking** ____

Please describe any other pertinent health information you are aware of:

____
____
____

General Health History

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OVER THE PAST **6** MONTHS

General Symptoms
- ☐ Headaches/Migraines
- ☐ Allergies
- ☐ Sleeping Problems
- ☐ Frequent Colds/Flu
- ☐ Fever/Chills

Muscle & Skeletal System
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain/Stiffness
- ☐ Shoulder/Elbow/Arm Pain
- ☐ Hand/Wrist/Finger Pain
- ☐ Walking Problems
- ☐ Hip/Leg Pain/Sciatica
- ☐ Foot Pain
- ☐ Jaw Pain or Clicking
- ☐ Difficulty Chewing

Nerve System
- ☐ Numbness - Where?
- ☐ Cold/Tingling Extremities - Where?
- ☐ Weakness/Paralysis - Where?
- ☐ Dizziness
- ☐ Confusion/Depression
- ☐ Seizures/Convulsions
- ☐ Face Pain/Tic Doulareaux
- ☐ Hyperactivity

Gastro-intestinal System
- ☐ Abdominal Pain/Cramps
- ☐ Heartburn/Indigestion
- ☐ Hiatal Hernia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Black/Bloody Stool
- ☐ Liver Problems/Jaundice
- ☐ Gall Bladder Problems
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst

Cardiovascular & Respiratory Systems
- ☐ Breathing Difficulty/Wheezing/Asthma
- ☐ Lung Problems/Congestion/Cough
- ☐ Chest Pain
- ☐ Heart/Artery Disease
- ☐ Circulation Problems
- ☐ Irregular Heartbeat
- ☐ Blood Pressure Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Eyes - Ears - Nose - Throat
- ☐ Vision Problems
- ☐ Crossed Eyes
- ☐ Hearing Difficulty
- ☐ Sore Throat/Laryngitis
- ☐ Chronic Stuffed/Runny Nose
- ☐ Sinus Problems/Infections/Headaches
- ☐ Nose Bleeds
- ☐ Itchy/Watery Eyes
- ☐ Enlarged Glands
- ☐ Loss of Smell or Taste Perception
- ☐ Ear Aches/Noises/Infection

Urinary System
- ☐ Pain or Burning Upon Urination
- ☐ Discolored Urine
- ☐ Excessive Urination Frequency
- ☐ Urinary Hesitancy
- ☐ Kidney Disorders
- ☐ Bladder Disorders
- ☐ Bed-Wetting/Incontinence

For Men Only:
- ☐ Impotence
- ☐ Prostate Disorders

For Women Only:
- ☐ PMS
- ☐ Menstrual Cramps
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain
- ☐ Yeast Infection
- ☐ Breast Pain/Lumps
- ☐ Menopause Symptoms
- ☐ Infertility

Date of your last menstrual period________________________

Are you Pregnant?

☐ Yes ☐ No ☐ Not Sure

ACCIDENT/INJURY HISTORY:

Name ____________________________________ **Date:** ____________

- □ Male □ Female Age ________ Height______ Weight______ Date & Time of Accident_________________
- **Please describe the accident:**____

____

Please check the box next to any of the following conditions that you have had since the accident:

□ Neck Pain/Stiffness □ Headaches/Migraines □ Low Back Pain □ r Pain Between Shoulders

□ Shoulder/Elbow/Arm Pain □ Hand/Wrist/Finger Pain □ Walking Problems □ Hip/Leg Pain/Sciatica

□ Dizziness □ Confusion/Depression □ Vision Problems □ Mid Back Pain

□ Hearing Difficulty/Ear Noises/Ringing □ Difficulty Standing □ Difficulty Sleeping

□ Numbness - Where?_______________________ □ Cold/Tingling Extremities - Where?______________

□ Weakness/Paralysis - Where?_____________________ □ Breathing Difficulty/Wheezing/Asthma

- **Were you the** □ Driver □ Front Passenger □ Rear Passenger?
- **If a traffic violation was issued, who received it?** □ Self □ Driver □ Person who hit your vehicle
- **Did the police come to the accident site?** □ Yes □ No
- **Were there any witnesses?** □ Yes □ No
- **Were you wearing a seatbelt?** □ Yes □ No
- **Which way was your head turned at time of impact?** ________________________
- **Was the vehicle equipped with airbags?** □ Yes □ No If Yes, did they inflate? □ Yes □ No
- **In relation to the base of your skull, where was the headrest?** □ above □ below □ at same level
- **What did your vehicle collide with?** □ another vehicle □ other (explain):_______________________________________
- **Did any part of your body strike anything in your vehicle?** If Yes, describe:_______________________________

____
- **Make & Model of vehicle you were in**____
- **Street location of accident:**____
- **Approximately what speed were you traveling?** ________mph □ My vehicle was stopped
- **Approximately what speed was the other vehicle traveling?** __________________mph
- **What part of your vehicle was hit?** □ Rear □ Front □ Right Side □ Left Side □ other:______________________
- **Did you go to the hospital?** □ Yes □ No Name of the hospital:___________________________________
- **If yes, when did you go?** □ just after the accident □ next day □ 2 days or more after
- **How did you get to the hospital?** □ ambulance □ private transportation

- **Were x-rays taken?** ☐ Yes ☐ No If yes, what areas of your body?________________________________
- **Where drugs prescribed?** ☐ Yes ☐ No Type?___________________________
- **What type of treatment did you get ?**____
- **Which best describes your discomfort?** ☐ ache ☐ sharp/stabbing ☐ burning ☐ pins & needles ☐ numbness
- **Rate how much it bothers you - on a scale of 1 (discomfort) to 10 (extreme pain)**___________________
- **What activities/positions/etc. makes it feel worse?**____
- **What makes it feel better?**____
- **Does your current condition ever cause you to be:** ☐ moody ☐ irritable ☐ unpleasant ☐ depressed ☐ angry
- **What is your occupation?**________________________**How does your condition interfere with your work?**

☐ decreased productivity ☐ hard to concentrate ☐ can't work without pain ☐ had to stop working/disabled

- **What activities have you been forced to stop or hesitate doing because of your condition?**

☐ athletic/exercise activities ☐ r household work - lifting, etc. ☐ gardening ☐ walking ☐ biking ☐ dancing

☐ running ☐ other (please list):____

- **Check any of the following drugs & treatments you have used unsuccessfully to get rid of this problem:**

  ☐ tylenol ☐ advil ☐ aspirin ☐ aleve ☐ motrin ☐ antacids ☐ sinus medicine ☐ blood pressure pills

  ☐ muscle relaxers ☐ ice ☐ heat ☐ massage ☐ herbal or remedies ☐ bengay or other ointments

  ☐ pain medicine injections ☐ prescription pain medicine (please list):_____________________________________

  ☐ bed rest ☐ other (please list):____

- **Check off any tests or evaluations you have had for this condition(s):**

☐ x-ray ☐ MRI ☐ CAT scan ☐ bone scan ☐ blood tests ☐ other_______________________________________

- **Check off any type of doctors you've consulted for this condition(s):**

☐ general medical physician ☐ orthopedist's ☐ neurologist ☐ rheumatologist ☐ cardiologist's

☐ dermatologist ☐ podiatrist ☐ dentist ☐ pediatrician ☐ psychiatrist ☐ allergist ☐ OB/GYN ☐ herbalist

☐ gastrointestinal/internal medicine ☐ urologist ☐ oncologist ☐ opthalmologist ☐ pain clinic

☐ lung specialist ☐ ear, nose & throat ☐ sports medicine ☐ physical therapist ☐ osteopath ☐ physiatrist

☐ **other chiropractor(s):** Who?____

How long and often did you go?_____________________ When was your last appointment

Please describe any other pertinent health information you are aware of:

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☐ Arthritis ☐ Tuberculosis ☐ Diabetes ☐ Epilepsy ☐ Whooping Cough ☐ Cancer ☐ Mental Disorders
☐ Measles ☐ Thyroid ☐ Eczema ☐ Psoriasis ☐ Tonsillitis ☐ Tested HIV positive

- **Have you ever had any surgery?** ☐ yes ☐ no Type:____
- **Have you ever been hospitalized?** ☐ yes ☐ no Why?____

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: ______________________________________ Birth Date: _____ / _____ / _____

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other________________________

Height: ______ feet ______ inches

Weight: _________ lbs

Phone #: ___________

Zip Code: __________

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other ________________________

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other ________________________

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? ____

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes…

What? _______________________________ _______ mg

What? _______________________________ _______ mg

What? _______________________________ _______ mg

Last known blood pressure reading? _____/_____

If unknown was it normal? _______ Are you medicated for blood pressure? ________

The authorization form below is written in specialized legal terms. Basically, your signature at the bottom authorized Dr. David N. Block to provide care to you on assignment, which means you will receive care, without having to pay up-front for health services. This authorizes our clinic to receive payments for your care directly from insurance companies and/or your attorney upon settlement of your case. However, this lien also authorizes the fact that the doctor is not legally bound to await payment for his services (although it is our policy to wait under normal circumstances). It also states that if payment for services is not eventually provided by you, that you will be responsible for any additional costs, such as reports, court fees or collections due to any debt. Please read and sign this form.

RE: AUTHORIZATION FOR RELEASE OF RECORDS, DOCTOR'S LIEN AND ASSIGNMENT OF BENEFITS

DATE OF INJURY:__________________

I do hereby authorize Dr. David N. Block to furnish my attorney and involved insurance companies with a full report of my examination, diagnosis, treatment, prognosis, etc., in regard to the accident in which I was involved. For valuable consideration, I hereby assign such sum of my proceeds received from my claim from this accident to Dr. David N. Block to fully pay for services rendered to me. I understand and agree that in order for my case to be settled adequately, the doctor needs to formulate a comprehensive report. This report details all aspects of my case and recovery, including all procedures conducted and the clinical impressions rendered from those procedures.

I hereby authorize and direct my attorney, my insurance company, the defendant, the defendant's insurance company, and/or the defendant's attorney to pay directly to Dr. David N. Block such sums as may be due and owing him for health services rendered to me by reason of this accident and to withhold such sums from any disability benefits, medical payment benefits (medpay), no-fault benefits, health and accident benefits or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict as may by necessary to adequately protect said doctor. And I hereby further give a lien on my proceeds to Dr. David N. Block against any and all proceeds of my settlement, judgment or verdict as the result of the injuries for which I have treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Dr. David N. Block for all bills submitted by him for services rendered me and that this agreement is made solely for Dr. David N. Block's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I also accept full responsibility for payment of all charges incurred as well as attorney's fees of 33.3% and any and all related costs of collection, including filing fees, should such action become necessary. I also agree not to list Dr. David N. Block in any bankruptcy that I may declare. I also understand and agree that any bankruptcy which I may declare has no bearing on any moneys owed to Dr. David N. Block. Interest rates on unpaid balances is 19.8% and begins from the time an account has become 30 days past due or has been considered delinquent.

DATE:________________ **PATIENT'S SIGNATURE:____**

DATE:________________ **WITNESSED BY:____**

The undersigned attorney for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named, in accordance with the conditions stated above.

DATE:________________ **ATTORNEY'S SIGNATURE:______________________________________**

PLEASE DATE, SIGN AND RETURN THE ORIGINAL TO THE DOCTOR'S OFFICE AND KEEP THE COPY FOR YOUR RECORDS.