NOTARO CHIROPRACTIC

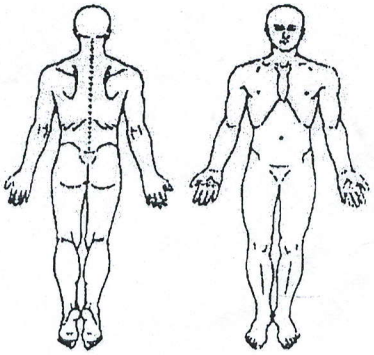
GRAND ISLAND CHIROPRACTIC
2283 GRAND ISLAND BLVD
GRAND ISLAND, NY 14072
(Town Hall Plaza)
(716) 773-2222
FAX (866) 907-6157

NOTARO CHIROPRACTIC
10158 NIAGARA FALLS BLVD
NIAGARA FALLS, NY 14304
(Como Airport Plaza)
(716) 298-0368
FAX (866) 907-6157

NOTARO CHIROPRAC TIC
4754 N. French Road
East Amherst, NY 14051
(The Commons)
(716) 688-8815
FAX (866)907-6157

PATIENT HISTORY (Please Print)
(Please feel free to add information to the back of this sheet)

Name: _____ Date of Birth: _____ Sex: M F
Address: _____
(Street) (City) (State) (Zip)
Marital Status: _____ Weight: _____ Height: _____
Social Security Number: ___-__-____ Email: _____
Home Phone: _____ Cell Phone: _____ Accepts Text Msg? YES NO
(Please circle which phone number to call for appointment reminders)
Health Insurance Company Name: _____ Group #: _____
ID #: _____ Family Doctor Name: _____ Phone: _____
Name of person on insurance: _____
How did you hear about us? (Please explain) _____
Describe presenting complaint(s) in detail. Please indicate the current complaints you are experiencing by marking the areas on the image below :



_____
Approximate DATE your symptoms BEGAN: _____
Give complete description of HOW your symptoms began:
_____
Are you currently working? Yes or No
*If no: Reason for unemployment: _____
Occupation & Name of Employer: _____
Address of Employer: _____
****WERE YOU HURT AT WORK? YES or NO
****WERE YOU HURT IN AN AUTOMOBILE ACCIDENT? YES or NO
Would your employer be interested in complimentary safety lecture by our doctors? _____
Would you be interested in a nutritional program & supplements? _____
Have you EVER seen a Chiropractor? YES or NO
If yes, who? _____
Have you had X-rays, MRI, CT-Scan, Bone Scan, or Blood Work (Please Circle?)
Where: _____ When: _____
Have you EVER been treated for or suspected of having cancer in the past or present? _____
List ALL medications, vitamins, minerals, and herbs you take: _____
_____
List ALL specific allergies/reactions to drugs, foods or other substances you have:
_____
Have you been in or had ANY accidents or injuries: YES or NO
If yes: When _____ Please describe in detail: _____
_____
Have you had ANY surgeries or fractures: YES or NO
Please list along with the approximate date: _____
Family History: Please list the illness/disease and the family member associated:

Who to contact in case of an Emergency: _____ Phone: _____

Signature: _____ Date: _____

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Patient Name: _____

AUTHORIZATION FOR RELEASE OF RECORDS:

To _____, I hereby authorize you to release to GRAND ISLAND CHIROPRACTIC any information including the diagnosis and records of any treatment or examination rendered to me during my period of treatment.

Date:_____ Signature:_____Date:_____ Witness:_____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I authorize payment of any medical benefits to be paid directly to GRAND ISLAND CHIROPRACTIC OFFICE for any service rendered to me.

Date:_____ Signature:_____Date:_____ Witness:_____

NOTICE OF PATIENT PRIVACY

By signing the below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

Name(Printed)_____ Signature:_____Date:_____ Witness:_____

_____ _____

Signature of Legal Representative Relationship
(ex.Attorney-In-Fact, Guardian, Parent if a minor)

CONSENT TO TREAT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of benefits, the risks and the side effects of the treatment and consequences of not having the proposed treatment. I understand that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all the risks. I wish to rely on the doctor to exercise judgment during the course of the treatments which they feel at the time, based upon what is known, is in my best interest. My doctor has responded to all of my requests for information about the proposed treatment. I have, or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent. By signing below, I authorize treatment.

Date: _____ Signature: _____ Date: _____ Witness:_____

ACKNOWLEDGEMENT OF FINANCIAL LIABILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, all collection and/or legal fees on any unpaid account referred for collection, and charges denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges, which may not be approved. The insurance company will review any/all documentation submitted by Grand Island Chiropractic for review for medical necessity and base their approval/denial upon this documentation. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals etc. I understand that this office agrees to notify me if a service is not covered and will notify me if the insurance company does not approve my care as soon as possible. If a treatment plan is approved, this office will make me aware of the number of office visits allowed. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for the insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance plan determine to be not medically necessary.
I have read and understand my obligations for payment for care in the absence of insurance coverage.

_____ _____ _____

Print Name Signature Date