

**Grand Island Chiropractic**  
 2283 Grand Island Blvd  
 Grand Island, NY 14072  
 (716)773-2222  
 Fax: (866)907-6157

**Notaro Chiropractic**  
 10158 Niagara Falls Blvd  
 Niagara Falls, NY 14304  
 (716)298-0368  
 Fax: (866)907-6157

**Notaro Chiropractic**  
 4754 North French Rd  
 East Amherst, NY 14051  
 (716)688-8815  
 Fax: (866)907-6157

**Notaro Chiropractic**  
 950 Maple Rd  
 Williamsville, NY 14221  
 (716)580-3044  
 Fax: (866)907-6157

**Patient History (Please Print)**

Please use the back of this page to provide any additional relevant information.

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 Messages? YES NO

(Please circle which phone number to call for appointment reminders)

How did you hear about us? (Please explain; we have a referral program!) \_\_\_\_\_

**Insurance**

Health Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID #: \_\_\_\_\_ Family Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Person on insurance: \_\_\_\_\_

**Symptoms**

Describe presenting complaint(s) in detail. Please indicate the current complaints you are experiencing by marking the areas on the image: \_\_\_\_\_

Approximate date your symptoms began: \_\_\_\_\_

Description of how your symptoms began: \_\_\_\_\_

Are you currently working: YES NO

\*If no, reason for unemployment: \_\_\_\_\_

Occupation & name of employer: \_\_\_\_\_

Address of employer: \_\_\_\_\_

Were you hurt at work: YES NO

Were you hurt in an automobile accident: YES NO

Would your employer be interested in complimentary safety lecture by our doctors? YES NO

Would you be interested in a nutritional program & supplements? YES NO

Have you ever seen a Chiropractor? YES & doctor's name is/was \_\_\_\_\_ NO

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? YES NO

Please list all medications, vitamins, minerals, and herbs you take: \_\_\_\_\_

Please list all allergies/reactions to drugs, foods or other substances you have: \_\_\_\_\_

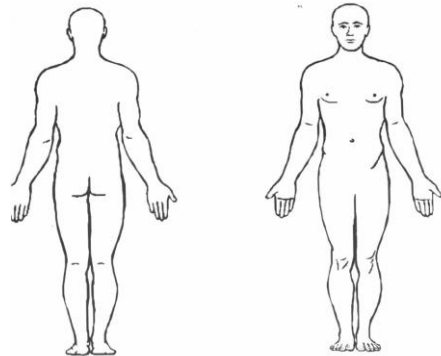
Have you been in or had ANY accidents or injuries: NO YES When: \_\_\_\_\_ Please describe: \_\_\_\_\_

Have you had any surgeries or fractures: NO YES List with dates: \_\_\_\_\_

Please list any family history of illnesses or diseases and the family member associated: \_\_\_\_\_

Emergency Contact – Name: \_\_\_\_\_ 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 for any services 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 judgement 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 charge 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 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 determines 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



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## **NOTIFICATION CONSENT:**

Notaro Chiropractic will now be sending reminder texts and calls for your convenience on upcoming appointments as friendly reminders.

Notaro Chiropractic will also be sending emails monthly for our new monthly promotions on supplies

\*By signing this form, you agree to receive text messages, phone call and emails regarding appointments and promotions from Notaro Chiropractic, its management company Chiropractic Office Solutions, agents, contractors and assignees.

Audio and visual recordings may be used at the front desk for quality assurance. The recordings are kept secure and are destroyed pursuant to a routine deletion policy.

Thank you!

Signature: \_\_\_\_\_

Date: \_\_\_\_\_