

# WELCOME

Florida Spine & Disc Institute

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

## Patient Information

Name: \_\_\_\_\_  
Last First MI

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Other) \_\_\_\_\_

Can we call you at work?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

## Accident Information

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

## Financial Information

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

## Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Harris Family Chiropractic, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_

# Health History

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |                                     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        |   |
|   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Other _____          |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any supplements you are currently taking (vitamins/herbs/minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |                                      |

Do you exercise:  Frequently  Moderately  Occasionally  None

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

Do you sleep on your:  Back  Side  Stomach Do you use a cervical pillow?  Yes  No

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

**SIGNATURE (X)** \_\_\_\_\_ **DATE** \_\_\_\_\_

## CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

### X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: \_\_\_\_\_

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Florida Spine & Disc Institute

Florida Spine & Disc Institute  
4 Pearl Drive, Suite #1  
Ormond Beach, FL 32174

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I acknowledge that I have reviewed the Notice of Privacy of Florida Spine & Disc Institute. (Please initial one of the following options and signed below)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I wish to receive an electronic copy of Privacy Notice.

My email address is: \_\_\_\_\_ @ \_\_\_\_\_

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

\_\_\_\_\_ I acknowledge that it is the policy of Florida Spine & Disc Institute to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

\_\_\_\_\_ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Andrew Harris, about my concerns.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Office Staff)

\_\_\_\_\_  
Date