NEW PATIENT FORM

FAMILY CHIROPRACTORS OF MONTCLAIR
39 WATCHUNG PLAZA
MONTCLAIR NJ 07042

Patient Name: ______________________________ Sex: Male / Female Date: __________________________

Address_____________________________________ City _____________________State_______ Zip___________

Home Phone (   ) ________________________ Cell Phone (   ) ____________________ Age: ________

Date of Birth: ____/_____/________ Employer: ____________________ Email: ______________________________

Subscriber Name: __________________________________ Subscriber's: D.O.B: __________________________

Relation to Patient: ______________ Health Ins. Plan: __________________ # OF FAMILY MEMBERS ON PLAN ________

Vitals:

Height: __________________ Weight: __________________ Blood Pressure: ___________/____________

Ethnicity & Personal Status (Please Circle One)

Hispanic or Latino	Single
Not	Married
Hispanic / Latino	Divorced

Race: (Please Circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Italian
- ☐ Mandarin
- ☐ French
- ☐ Japanese
- ☐ Cantonese
- ☐ German
- ☐ Other: _________

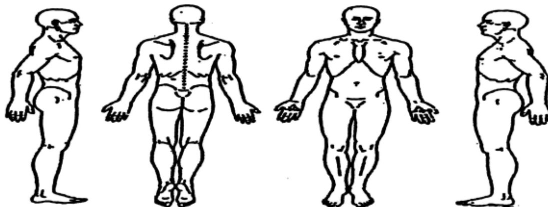
Smoking Status:

- ☐ Smoke Every Day
- ☐ Smoke Some Days
- ☐ Former Smoker
- ☐ Never Smoked

Have you been diagnosed with: (Please circle)

Asthma? Y / N	Diabetes? Type? Y / N I / 2	High Blood pressure? Y/ N

1. Indicate on the drawings below where you have pain / symptoms:



2. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

3. Please choose the location of the problem?

Head	**Shoulders**	**Hand**	**Legs**
Jaw	**Arm**	**Mid Back**	**Knee**
Neck	**Elbow**	**Low back**	**Ankle**
Upper Back	**Wrist**	**Hip**	**Foot**

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other: ___________________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. What do you do at work?

□ SIT - Most / Half / Some of the day □ STAND - Most / Half / Some of the day □ Manual Labor

□ Computer - Most / Half / Some of the day □ Drives - Most / Half / Some of the day □ Travels Frequently

9. What is your Occupation?

□Trader □Homemaker □Professional/Executive □Truck Driver □Teacher □Student

□Tradesperson □Retired □Laborer □Unemployed □ Other ___________________

10. How would you rate your overall health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

11. What kind of regular exercise do you perform?

□ Strenuous □ Moderate □Light □ None

12. What type of exercise do you enjoy?

□aerobics □bicycle □hike □jog/run □ski □swim □volleyball □ lift weights
□basketball □football □hockey □martial arts □soccer □tennis □baseball/softball
□lacrosse □golf □walk □yoga □pilates OTHER:______________________________________

13. Indicate if you have any immediate family members with any of the following: M for Mother- F for Father

□ Rheumatoid Arthritis M / F □ Diabetes M / F □ Lupus M / F
□ Heart Problems M / F □ Cancer M / F □ ALS M / F

14. for each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:____________________________				

15. Please list all Prescription Medications you are currently taking:

Check here if you are not taking any medications: □

Medication: i.e. Lipitor	**# of MD refills issued?**	**Quantity of Pills per Refill:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

***16.* Are you allergic to any medicines? Please list each drug on a new line:**

Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. penicillin	**Symptom if taken:** i.e. headache

17. Have you ever been hospitalized? ☐ No ☐ Yes

If yes, why? ____

18. Have you had significant past trauma/surgery? ☐ No ☐ Yes

If yes, explain: ____

19. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ other: _____________
□ Massage Therapist □ Physical Therapist □ No one

20. How long have you had this problem? ______________________Day/Days/Months/Year/Years

21. How do you think your problem began?

____

22. What aggravates your problem?

Always There / Bending / Biking / Deep Breaths / Stairs / Coughing / Driving / Golfing
Painting / Standing

Picking up child / Running or Jogging / Playing sports / Sleeping / Sneezing / Standing / Stress
Using Phone

Sitting / Bathing / Traveling / Turning over in bed / Weather change / Work / Computer / Lifting
Carrying

Pushing / Pulling / Dressing / Exercising / Household Chores / Gardening / Shoveling / Reaching
Raking OTHER:____

23. Anything else pertinent to your visit today? ____

24. Have you had an influenza vaccination this year? □ Yes □ No

25. Whom may we thank for your referral? ☺ ____

PATIENT'S ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT FAMILY CHIROPRACTORS OF MONTCLAIR IS PERMITTED BY LAW, TO USE MY PERSONAL HEALTH INFORMATION, TO FACILITATE PAYMENT OF ANY FEES AND EXPENSES. FAMILY CHIROPRACTORS OF MONTCLAIR HAS AGREED TO ASSIST ME IN BILLING, MY HEALTH INSURANCE, AUTO INSURANCE AND ANY AND ALL OTHER APPLICABLE COLLATERAL SOURCES, AND ALTHOUGH THE PRACTICE WILL AWAIT THEIR DIRECT PAYMENT, I AGREE I AM FULLY AND PERSONALLY RESPONSIBLE, FOR ALL FEES I INCUR IN CONNECTION WITH SERVICE RENDERED FOR THE PURPOSE OF TODAY'S ENCOUNTER, AS WELL AS ANY FUTURE SERVICES, FOR ANY CONDITIONS, KNOWN OR AS OF YET UNKNOWN.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATE'S STATUTES.

Patient Signature____

Date:___________________

Statement of Non-Accident

I, ________________________________, am currently receiving chiropractic care at this facility. Please know that this care is **not related** to any auto accident, worker's compensation injury, or any other type of injury in which there is a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

_________________________________ _________________________________

Print Name Signature

Coordination of Benefits Statement

Do you have a Secondary Insurance? (circle one) **YES** **NO**

Name of Secondary Insurance Company____

Name of Policy Holder: _______________________ Policy ID #:_________________________________

_______________________________________ ____

Print Name Signature

HIPPA FORM

We are required by State and Federal Law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the rights to alter or amend the terms of this privacy notice. IF changes are made to our privacy notice we will notify you, in writing, as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

Dr. Luis Mizraji. Privacy Officer
If you would like further information about our privacy policies and practices, please contact:

Dr. Luis Mizraji. Privacy Officer
You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.
This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

_______________________________________ _____________________________________ ________________

Name (please print) Signature Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

________________________________ _______________________________ ______________

Personal Representative (please print) Personal Representative Signature Date