# Patient Information Form

| EMAIL: | Claim #: |
|---|---|
| | Cell: - |
| | Phone: ( ) - |

| First Name: | M.I. | Last: |
|---|---|---|
| Address: | City: | State: / Zip: |
| Age: / Sex: / DOB: / / | Marital Status: ☐S ☐M ☐W ☐D | Spouse: |
| SS#: - - / Occupation: | Employer: | |
| Work Phone: ( ) - | Work Address: | |
| Referred By: | Person Responsible for this Account: | |
| Contact in Case of Emergency: | Phone: ( ) - | |

**MEDICAL/FAMILY HISTORY** Please indicate which conditions have been experienced by marking the appropriate boxes:

**S = SELF M = MOTHER F = FATHER**

| S | M | F | Condition | S | M | F | Condition | S | M | F | Condition |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | AIDS/HIV | ☐ | ☐ | ☐ | Indigestion | ☐ | ☐ | ☐ | Multiple Sclerosis |
| ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ | Dislocated Joints | ☐ | ☐ | ☐ | Muscular Dystrophy |
| ☐ | ☐ | ☐ | Arthritis | ☐ | ☐ | ☐ | Epilepsy | ☐ | ☐ | ☐ | Neck Pain |
| ☐ | ☐ | ☐ | Asthma | ☐ | ☐ | ☐ | German Measles | ☐ | ☐ | ☐ | Numbness |
| ☐ | ☐ | ☐ | Back Pain | ☐ | ☐ | ☐ | Headaches | ☐ | ☐ | ☐ | Osteoporosis |
| ☐ | ☐ | ☐ | Bladder Trouble | ☐ | ☐ | ☐ | Heart Trouble | ☐ | ☐ | ☐ | Poor Circulation |
| ☐ | ☐ | ☐ | Bone Fracture | ☐ | ☐ | ☐ | Reproductive Disorders | ☐ | ☐ | ☐ | Artery Occlusion |
| ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ | DVT *(Deep Vein Thrombosis)* |
| ☐ | ☐ | ☐ | Chest Pain | ☐ | ☐ | ☐ | High Cholesterol | ☐ | ☐ | ☐ | Aneurysm |
| ☐ | ☐ | ☐ | Concussion | ☐ | ☐ | ☐ | Kidney Disease | ☐ | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | ☐ | Convulsions | ☐ | ☐ | ☐ | Bowel Control Loss | ☐ | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ | Menstrual Cramps | ☐ | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | ☐ | Stroke/TIA *(Transient Ischemic Attack/Mini Stroke)* | ☐ | ☐ | ☐ | Pacemaker/Defibrillator | ☐ | ☐ | ☐ | Rheumatic Fever |
| | | | | ☐ | ☐ | ☐ | Sinus Trouble | ☐ | ☐ | ☐ | Polio |

| Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No | |
|---|---|
| Describe Condition: | |
| Date of Last Physical Exam: | |
| **SURGICAL HISTORY** | |
| 1. | Date: |
| 2. | Date: |
| 3. | Date: |
| Do you have a metal implant? ☐ Yes ☐ No | Ever been gunshot? ☐ Yes ☐ No |
| **ACCIDENT HISTORY** | |
| 1. ☐ Job ☐ Auto ☐ Other: | Date: |
| 2. ☐ Job ☐ Auto ☐ Other: | Date: |
| 3. ☐ Job ☐ Auto ☐ Other: | Date: |
| Patient's Signature: | Date: / / |

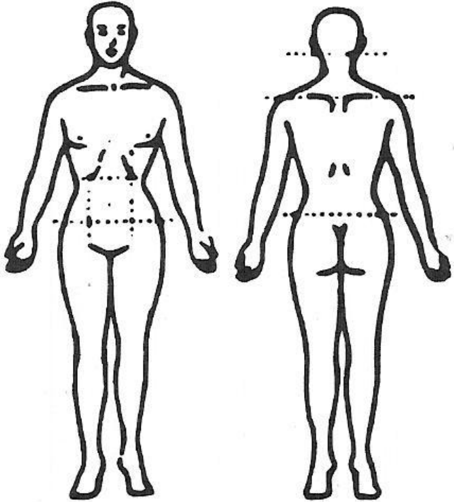
*Jewell Chiropractic*
*Dr. John Frink, D.C*

## Patient Complaints

PLEASE ASK RECEPTIONIST IF YOU NEED ASSISTANCE

Using the provided symbols, please indicate the areas your pain affects:

ACHE: **^^^^^^** BURNING: **----------**
NUMBNESS: **000000** PINS & NEEDLES: **……….**
STABBING: ***////////*** OTHER: **XXXXXXXX**



Please mark an "X" on the line indicating the severity of your pain:

1 ◄────────────────► 10
No Pain Worst Pain Possible

**PLEASE LIST MAJOR COMPLAINTS**

| |
|---|
| |
| |
| |
| |
| |
| |
| |
| |

Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night

**When and how did your symptoms occur** *(What were you doing when the pain began)***?**

________________________________________________
________________________________________________
________________________________________________

**Date Occurred: ______/_______/__________**

Symptoms/Complaints: ☐ Come and Go ☐ Are Constant

Symptoms have persisted for how many: hour(s) day(s) week(s) month(s) year(s)

| |
|---|
| Symptoms developed from: ☐Job related Injury ☐Auto Accident ☐Other Accident ☐Illness ☐Unknown Cause ☐Gradual onset |
| **What does your pain prevent you from doing**? |
| |
| |
| Have you ever had these symptoms before? ☐ Yes ☐ No When? |
| Radiological Studies done in the past 2 years (Xrays, MRI, CT scans etc)? **Y** **N** |
| If Yes, When and where were they performed? |
| Name and Location of Doctor(s) previously seen for present condition(s)? |
| 1. |
| 2. |
| Are you allergic to any medications? ☐ Yes ☐ No If Yes, which ones? |
| Are you taking any medications? ☐ Yes ☐ No **If Yes, please provide us with a complete dosage list** |
| Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Date of last menstrual Period: |
| Please check the following that **aggravate** your condition: |

| | | | | | |
|---|---|---|---|---|---|
| ☐ Bending | ☐ Reaching | ☐ Straining at Stool | ☐ Coughing | ☐ Sitting | ☐ Walking |
| ☐ Lifting | ☐ Sneezing | ☐ Lying Down | ☐ Turning your head | ☐ Standing | |

Please check the following activities that **relieve** your condition:

| | | | | |
|---|---|---|---|---|
| ☐ Bending | ☐ Sitting | ☐ Standing | ☐ Lying Down | ☐ Walking |

Fees are payable at the time x-rays, examination and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic

| Patient's Signature: | Date: |
|---|---|

# Complaint: NECK PAIN

| HOW OFTEN? | ☐ Intermittent (0-25%) |
|---|---|
| PICK ONE: | ☐ Occasional (26-50%) |
| | ☐ Frequent (51-75%) |
| | ☐ Constant (75-100%) |
| | |
| SEVERITY? | ☐ Mild |
| PICK ONE: | ☐ Mild to Moderate |
| | ☐ Moderate |
| | ☐ Moderate to Severe |
| | ☐ Severe |
| | ☐ Very Severe |
| | |
| MOVEMENT DIFFICULTY? | ☐ Inflexible |
| PICK ANY: | ☐ Restricted |
| | ☐ Spasm |
| | ☐ Stiffness |
| | ☐ Cramps |
| | |
| SENSATIONS? | ☐ Crawling |
| PICK ANY: | ☐ Dead |
| | ☐ Numb |
| | ☐ Pins & Needles |
| | ☐ Prickly |
| | ☐ Tingling |
| | |
| PAIN TYPES? | ☐ Achy |
| PICK ANY: | ☐ Burning |
| | ☐ Dull |
| | ☐ Electric Shock |
| | ☐ Excruciating |
| | ☐ Exquisite |
| | ☐ Hurting |
| | ☐ Numb Ache |
| | ☐ Pounding |
| | ☐ Pulsating |
| | |
| Area of Pain? | Down to: |
| Pick ONE: | Generalized in: |
| | Localized in: |
| | Migrating to: |
| | Radiating to: |
| | Shooting into: |

| AGGRAVATING FACTORS? | ☐ Anger |
|---|---|
| Pick ANY: | ☐ Arising from chair/sitting |
| | ☐ Bending |
| ☐ Pulling | ☐ Carrying |
| ☐ Pushing | ☐ Climbing Ladder |
| ☐ Reclining | ☐ Climbing Stairs |
| ☐ Repetitive Movement | ☐ Coughing |
| ☐ Sneezing | ☐ Depression |
| ☐ Standing | ☐ Driving |
| ☐ Stooping | ☐ Elevation |
| ☐ Straining at Toilet | ☐ Emotional Upset |
| ☐ Stress | ☐ Exercising |
| ☐ Swimming | ☐ External Rotation |
| ☐ Throwing | ☐ In/Out of Bed |
| ☐ Turning Head Left | ☐ In/Out of Car |
| ☐ Turning Head Right | ☐ Internal Rotation |
| ☐ Walking | ☐ Lifting |
| ☐ Walking Uphill | ☐ Looking Down |
| | ☐ Looking Up |
| | |
| RELIEVING FACTORS? | ☐ Chiropractic Adjustment |
| Pick Any: | ☐ Advil |
| | ☐ Aspirin |
| ☐ Resting | ☐ Cold |
| ☐ Rubbing Heat Liniment | ☐ Exercise |
| ☐ Rubbing Mineral Ice | ☐ Heat |
| ☐ Sitting | ☐ Hot Showers |
| ☐ Sleeping | ☐ Pain Pills |
| ☐ Tylenol | ☐ Reclining |

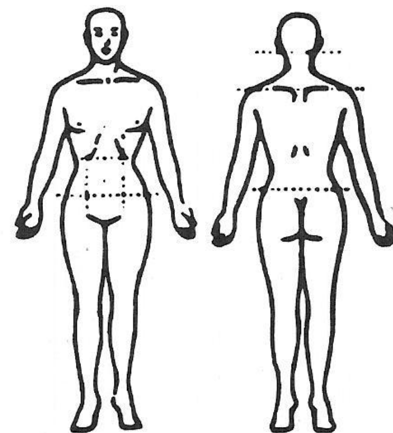
**Please draw in where you are affected using the provided symbols.**

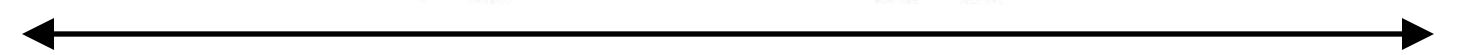
**Please mark an 'X' on the line indicating the severity of your pain.**

ACHE: ^^^^^^ BURNING: ----------

NUMBNESS: **000000** PINS & NEEDLES: ………..

STABBING: **////////** OTHER: **XXXXXXXX**





**1 – No Pain** **10- Worst Pain Possible**

NAME: ____________________________________________

DATE: ____________________________________________

# Complaint: LOW BACK PAIN

| | |
|---|---|
| HOW OFTEN? | ☐ Intermittent (0-25%) |
| PICK ONE: | ☐ Occasional (26-50%) |
| | ☐ Frequent (51-75%) |
| | ☐ Constant (75-100%) |
| | |
| SEVERITY? | ☐ Mild |
| PICK ONE: | ☐ Mild to Moderate |
| | ☐ Moderate |
| | ☐ Moderate to Severe |
| | ☐ Severe |
| | ☐ Very Severe |
| | |
| MOVEMENT DIFFICULTY? | ☐ Inflexible |
| PICK ANY: | ☐ Restricted |
| | ☐ Spasm |
| | ☐ Stiffness |
| | ☐ Cramps |
| | |
| SENSATIONS? | ☐ Crawling |
| PICK ANY: | ☐ Dead |
| | ☐ Numb |
| | ☐ Pins & Needles |
| | ☐ Prickly |
| | ☐ Tingling |
| | |
| PAIN TYPES? | ☐ Achy |
| PICK ANY: | ☐ Burning |
| | ☐ Dull |
| | ☐ Electric Shock |
| | ☐ Excruciating |
| | ☐ Exquisite |
| | ☐ Hurting |
| | ☐ Numb Ache |
| | ☐ Pounding |
| | ☐ Pulsating |
| | |
| Area of Pain? | Down to: |
| Pick ONE: | Generalized in: |
| | Localized in: |
| | Migrating to: |
| | Radiating to: |
| | Shooting into: |

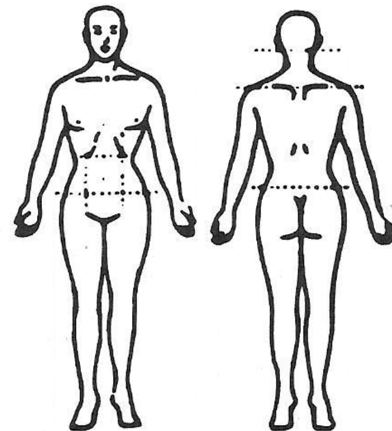
NAME: ___________________________________________

| | |
|---|---|
| AGGRAVATING FACTORS? | ☐ Anger |
| Pick ANY: | ☐ Arising from chair/sitting |
| | ☐ Bending |
| ☐ Pulling | ☐ Carrying |
| ☐ Pushing | ☐ Climbing Ladder |
| ☐ Reclining | ☐ Climbing Stairs |
| ☐ Repetitive Movement | ☐ Coughing |
| ☐ Sneezing | ☐ Depression |
| ☐ Standing | ☐ Driving |
| ☐ Stooping | ☐ Elevation |
| ☐ Straining at Toilet | ☐ Emotional Upset |
| ☐ Stress | ☐ Exercising |
| ☐ Swimming | ☐ External Rotation |
| ☐ Throwing | ☐ In/Out of Bed |
| ☐ Turning Head Left | ☐ In/Out of Car |
| ☐ Turning Head Right | ☐ Internal Rotation |
| ☐ Walking | ☐ Lifting |
| ☐ Walking Uphill | ☐ Looking Down |
| | ☐ Looking Up |
| | |
| RELIEVING FACTORS? | ☐ Chiropractic Adjustment |
| Pick Any: | ☐ Advil |
| | ☐ Aspirin |
| ☐ Resting | ☐ Cold |
| ☐ Rubbing Heat Liniment | ☐ Exercise |
| ☐ Rubbing Mineral Ice | ☐ Heat |
| ☐ Sitting | ☐ Hot Showers |
| ☐ Sleeping | ☐ Pain Pills |
| ☐ Tylenol | ☐ Reclining |

**Please draw in where you are affected using the provided symbols.**
**Please mark an 'X' on the line indicating the severity of your pain.**

ACHE: ^^^^^^ BURNING: ----------
NUMBNESS: **000000** PINS & NEEDLES: ………..

STABBING: **////////** OTHER: **XXXXXXXX**



**1 – No Pain** ⟵⟶ **10- Worst Pain Possible**

DATE: ___________________________________________

Twin Palms Health Centers d/b/a/
Jewell Chiropractic
579 S Indiana Ave, Englewood FL 34223

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

**First Name**:___________________________ **Last Name**:___________________________

**Email address:** __________________@__________________

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Alcohol Consumption (Circle one):** Every Day / Moderate / Minimal / Never

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ________________________________________________ Date:_________________

Height: _________ Weight:_____________ Blood Pressure:______ /______ HR _________

**JEWELL CHIROPRATIC (TWIN PALMS HEALTH CENTERS)**
**ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND**
**579 S. Indiana Ave, Suite, C, Englewood, FL 34223**
***Insurer and Patient Please Read the Following in its Entirety Carefully!***

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my Medical Insurance policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment in full at the time services are rendered. I understand this document will allow the provider to file claims to insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 payments from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the agreed amount. I as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my insurance to this provider. The insurer is directed to issue such a check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

**Disputes:** The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager and mailed to the attention of the **Office Manager.** See Fla. Stat. §673.3111.

**EUOs and IMEs:** If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered if the policy of insurance denies for any other services. The health care provider is given the power of attorney to: recieve/redeem check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient, or Explanation of Benefits for billed charges from the above named office.

**Release of information:** I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (insurance card, benefits, etc) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all provider; obtain any written and verbal statements the patient or anyone else provided to the insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits to obtain payment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

**Demand**: Demand is hereby made for the insurer to pay all bills within 90 days without reductions. The insurer is directed to pay the bills in the order they are received. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first. The insurer is instructed to inform, in writing, the provider of any dispute or payment or reductions due to contract must be indicated on the Explanation of Benefits (EOB).

**Certification:** I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

**Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name ________________________________ Patient's Signature ___________________________________________
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____________________________

*Jewell Chiropractic*

579 South Indiana Ave., Suite C
Englewood, FL 34223
Ph: (941) 474-4944 &  (941) 474-2475

**RECEIPT NOTICE OF PRIVACY PRACTICES (HIPPA)**
**WRITTEN ACKNOWLEDGEMENT FORM**

**Dr. John Frink, D.C.**

**I _______________________________ have read a copy of Jewell Chiropractic's Notice**
**(PRINT NAME)**
**of Patient's Privacy Practices.**

**Signature of Patient, Parent or Legal Guardian:**

**______________________________________**
**(SIGNATURE)**

**______________________**
**(DATE)**