NEW PATIENT INFORMATION FORM

PLEASE PRINT

GENERAL INFORMATION:

PATIENT LAST NAME:______________________ FIRST NAME:______________

ADDRESS:______________________ CARE OF:______________

CITY:__________ STATE:_____ ZIP:______ PHONE (HOME):__________

DRIVER'S LICENSE #:__________ NO. CHILDREN:____ PHONE (WORK):__________

OUT OF STATE ADDRESS:______________________ PHONE:__________

SPOUSE'S NAME:________ SPOUSE'S EMPLOYER:__________ NATIVE LANGUAGE:______

EMAIL ADDRESS:______________________

SEX: MALE OR FEMALE	MARRIED SINGLE WIDOWED DIVORCED	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER

PATIENTS EMPLOYER'S NAME:______________________

ADDRESS:______________________

CITY:__________ STATE:_____ ZIP:______

PHONE:__________ OCCUPATION:__________

EMPLOYED

☐ FULL TIME ☐ PART TIME

☐ RETIRED ☐ NOT EMPLOYED

STUDENT

☐ FULL TIME ☐ PART TIME

☐ NON-STUDENT

INSURANCE INFORMATION:

COMMERCIAL INSURANCE AND MEDICARE ONLY

PRIMARY INSURANCE COMPANY NAME

TYPE GROUP PRIVATE

MEMBERSHIP/CERT #:______________

POLICY/GROUP #:______________

COMPLETE ONLY IF PATIENT IS **NOT INSURED**

INSURED'S INFORMATION

INSURED'S NAME:__________

M or F MARRIED SINGLE WIDOW DIVORCED

PATIENT'S RELATIONSHIP TO INSURED:__________

INSURED'S DATE OF BIRTH:__________

INSURED'S EMPLOYER:__________

SECONDARY INSURANCE COMPANY NAME

TYPE GROUP PRIVATE

MEMBERSHIP/CERT #:______________

POLICY/GROUP #:______________

INSURED'S INFORMATION

INSURED'S NAME:__________

M or F MARRIED SINGLE WIDOW DIVORCED

PATIENT'S RELATIONSHIP TO INSURED:__________

INSURED'S DATE OF BIRTH:__________

INSURED'S EMPLOYER:__________

AUTOMOBILE ACCIDENT / WORKER'S COMPENSATION

INSURANCE COMPANY:__________ CLAIM #:__________ POLICY #:__________

ADDRESS:______________________ PHONE NUMBER:__________

CITY:__________ STATE:_____ ZIP:______ DATE OF INJURY:__________

ATTORNEY'S NAME:______________________ PHONE NUMBER:__________

ADDRESS:______________________ CONTACT NAME:__________

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

PATIENT'S SIGNATURE:______________________ DATE:__________

MICHAEL PAPA, D.C.

2632 West Indiantown Road
Jupiter, FL 33458
Phone: 561-744-7373 Fax: 561-743-1192

ASSIGNMENT OF BENEFITS

I, the undersigned patient, hereby assign my Personal Injury Protection insurance benefits under my policy of automobile insurance or all other applicable Private policies benefits under my medical insurance, for all causes of actions to **MICHAEL PAPA, D.C.** its subsidiaries and its agents, including but not limited to **MICHAEL PAPA, D.C.** for services rendered to the undersigned patient in accordance with Florida Statue 627.736(5), that would otherwise be payable to me for services rendered.

I fully understand that by the execution of this assignment of benefits, that I also grant **MICHAEL PAPA, D.C.,** its subsidiaries and its agents including but not limited to **MICHAEL PAPA, D.C.** full power of attorney and authority to act in or on my behalf insofar as the endorsing and cashing of checks as well as the execution of any other documents that may be related to this matter or claim. I agree to be fully responsible for the services provided regardless of settlement, judgment or verdict. I further direct my Private insurance carrier to provide any medical provider with an updated copy of the PIP Payment Log. A photocopy of this document shall be as binding as the original signature page.

PATIENTS/INSURED SIGNATURE____

INSURANCE COMPANY____

DATE____

DATE OF ACCIDENT____
(If applicable)

FINANCIAL POLICY AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless our staff has approved payment arrangements in advance. We accept CASH, CHECK, MASTER, DISCOVER, AMERICAN EXPRESS, or VISA CARDS. We will be happy to help you process your insurance claim-form for your reimbursement.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of **1.5 %** per month. We will gladly discuss your proposed treatment ans answer any questions relating to your insurance.

You must realize, however that:

1- You insurance is a contract between you, your employer and the insurance company. We are not a party to contract.

2- Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (50% or 80%) of "U.C.R."
"U.C.R." is defined as usual, customary and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical providers, our relationship is with you and not with your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage PLEASE do not hesitate to ask us. We are here to help you.

PATIENTS/INSURED SIGNATURE______________________________

INSURANCE COMPANY______________________________

DATE______________________________

DATE OF ACCIDENT______________________________
(If applicable)

PRIVACY PRACTICES ACKNOWLEDGMENT

Posted on Lobby Wall

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy practices and I have been provided an opportunity to review it.

NAME____________________________________BIRTHDATE___________________

SIGNATURE____

DATE__________________________

WAIVER

I acknowledge that I was given the opportunity to accept the Notice of Privacy Practices and have chosen not to receive that Notice or have it explained to me.

NAME____________________________________BIRTHDATE___________________

SIGNATURE____

DATE__________________________

X-RAY FILMS POLICY

Doctor's Property

Court Decisions

In absence of agreement to the contrary – between a private doctor and a patient or a representative – x-ray negatives or films are the **PROPERTY OF THE PHYSICIAN OR SUPPLIER TAKING THE X-RAYS INCIDENTAL TO TREATING OR EXAMINING THE PATIENT**. This is so, notwithstanding, the fee charged to the patient or the one who engaged the physician as part of the professional services rendered. **WHAT THE PATIENT PAYS FOR THE INTERPRETATION OF THE X-RAY FILM – NOT THE FILM ITSELF**. Under Florida Law, a patient is entitled to his medical records, but DOES NOT mean the patient is entitled to the X-RAY FILMS.

FLORIDA STATUTORY LAW APPLICABLE TO PHYSICIANS

There is no specific Florida Statue requiring an individual private physician to release or exchange an x-ray film to a patient or his personal representative or second physician. Florida Statue 455.241, to furnish copies of all reports made during the course of an examination or treatment, to any patient provides written authorization to one physician to furnish examination and treatment reports t another physician. Said reports must be furnished, but this does not mean release of the x-ray film. Florida, therefore, follows the general common law that an x-ray film is the property of the physician taking the film, and that the patient pays for the professional service for taking the x-ray and is entitled, only to a copy of the interpretative reports of the x-rays.

SUMMARY

X-RAY FILMS ARE THE PROPERTY OF THE PHYSICIAN TAKING THE FILM and are not required to be released or exchanged, except upon valid subpoena. Florida Statue 455.241 requires physicians, to furnish copies of all reports made during examination or treatment to a patient, personal representative of the patient or person designated in writing by the patient.

COPIES OF YOUR X-RAYS ARE AVAILABLE AT $12.00 PER COPY AND 72 HOURS NOTICE.

PATIENTS/INSURED SIGNATURE____

PRINT PATIENT NAME____

DATE____

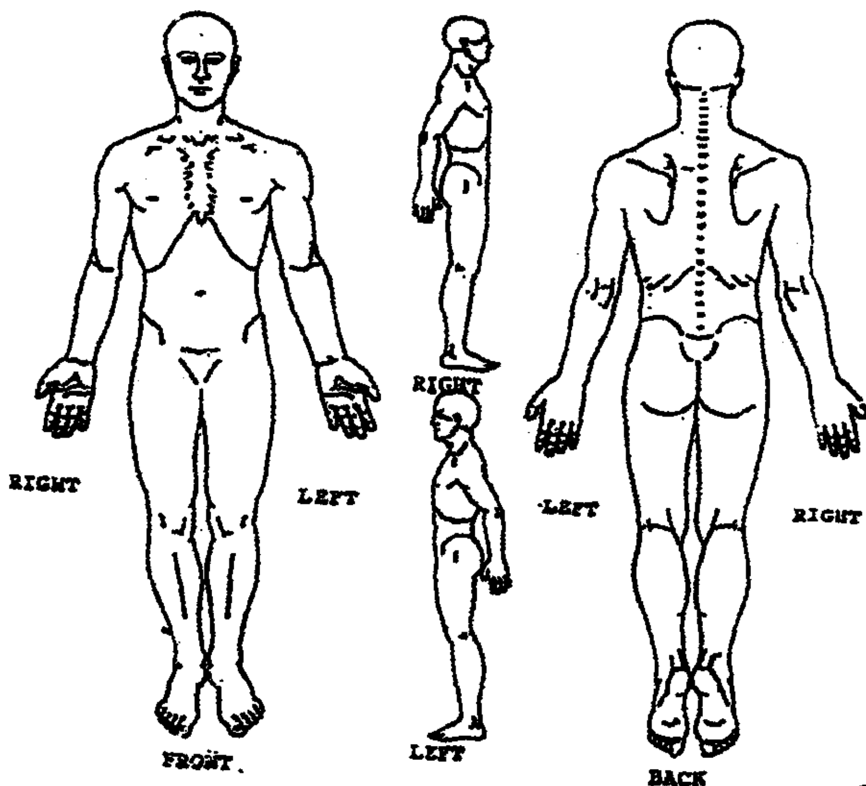
WITNESS____

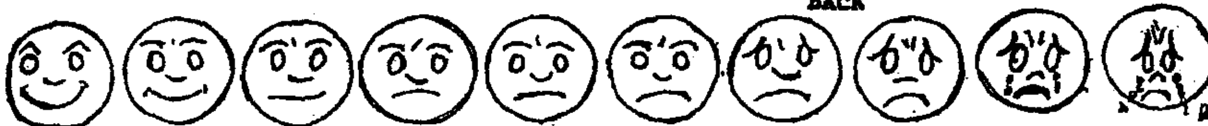
PAIN CHART

NAME________________________________ DATE______________________

Please indicate the type and area of your pain on the drawings below, by using the abbreviations provided:

D= Dull Pain	**T=Tingling**
B= Burning	**N= Numbness**
P= Sharp Pain	**S= Stiffness**





Please Give A Numeric Value To Your Pain On The Pain Scale Below

1 2 3 4 5 6 7 8 9 10

NO PAIN **VERY BAD PAIN**

Medical History Questionnaire
(Confidential Information)

Patient's Name:_______________________________________ Date:___________________

Reason for Visit:____

MEDICAL HISTORY: Please check the following:

High Blood Pressure.................yes____no____

Bleeding Disorder..................yes____no____

Anemia..............................yes____no____

Liver Disease.......................yes____no____

Heart Disease.......................yes____no____

Psychiatric Illness.................yes____no_____

HIV.................................yes____no_____

Skin Disease.....................yes____no____

Thyroid Disease.............yes____no____

Lung Disease...............yes____no____

Tuberculosis................yes____no____

Shortness of Breath.........yes____no____

Hepatitis...................yes____no____

Diabetes....................yes____no____

Please list any other medical history the doctor should be aware of:

____

____

Please list any prior hospitalizations below (e.g. accidents, etc.):

____

____

FAMILY HISTORY: Please give the age of living or age and cause of death.

Father:______________________________ Mother:______________________________

Siblings:_____________________________ Children:____________________________

MEDICATIONS: Please list medications you currently take, including <u>appetite suppressants, vitamins, herbal supplements, or any homeopathic medication:</u>

____

____

Do you take any Aspirin or any Aspirin-containing compound?_____If "YES," for what reason?

____

Do you have any ALLERGIES and/or SENSITIVITIES? (please indicate which, if any, are present):

Penicillin..........................yes____no____ Aspirin..............................yes____no____

Sulfa...............................yes____no____ Xylocaine...........................yes____no____

Any other Antibiotics.............yes____no____ Adhesive Tape.....................yes____no____

Codeine.............................yes____no____ Tetanus Toxic.......................yes____no____

Any Other..........................____

SOCIAL HISTORY:

Cigarette Smoking................yes____no____ How long since last use?___________________

Alcohol Use........................yes____no____ Drugs:_________________________________

Caffeine: None:______ Daily:______ How much?____________________________________

Do you take Vitamin E?______ If "YES," how much?_________________________________

SURGICAL HISTORY:

Please list all previous surgeries/operations, as well as cosmetic:

____Date_______________

____Date_______________

____Date_______________

Please list any complications or problems you experienced during or following the above procedures:

____

Do you wear corrective eye glasses or contacts?____

Date of last ophthalmology (eye) check up?____

Have you recently been under the care of a physician for any reason? Yes______ No______

If "YES," please explain:

____

Family Physician:____ Date of last check up:___________

Address:____ Phone:_______________________

Note: If you are scheduled for surgery at any time, please be advised that you cannot take aspirin or aspirin-containing products for a period of two weeks prior to your surgery. Evidence suggests that even small amounts of aspirin or other anti-inflammatory products can create bleeding problems in the apparently healthy adult. Acetaminophen, such as Tylenol, may be used as a substitute for aspirin.