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:_____ EMPLOYED

ADDRESS:_____ ☐ FULL TIME ☐ PART TIME

☐ RETIRED ☐ NOT EMPLOYED

CITY:_____ STATE:_____ ZIP:_____ STUDENT

PHONE:_____ OCCUPATION:_____ ☐ 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:_____

Jupiter West Medical Center
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)

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered.** This means that those services have **already been provided.**

   _____

   _____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(5)(b), Florida Statutes. It may not be electronically transmitted. Failure to furnish this form may result in nonpayment of benefits.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

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   _____

   _____

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Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her own hand):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. (Section 817.234(11)(b), Florida Statutes)

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes, and may **not** be electronically furnished. Failure to furnish the original may result in denial

OIR-B1-1571
10/03

RELEASE OF RECORDS

DATE: _____

ATTN: _____

TELEPHONE #: _____

FAX #: _____

PATIENT NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

I hereby authorize you to release to **Dr. Michael Papa, D.C.** and **Jupiter West Medical Center**, any information including the diagnosis and records of any treatment or examination rendered to me on _____ (dates of treatment).

PATIENTS SIGNATURE_____

WITNESS_____

POWER OF ATTORNEY

That I, (patient) _____
have made, constituted and appointed, and by these presents do make, constitute and appoint **MICHAEL PAPA, D.C.** (hereinafter Health Care Provider) true and lawful attorney for me and in my name, place a stead to endorse my name on all checks received from the insurance company/adjusting service (insurance company) _____ representing payment of PIP or medical payment coverage benefits payable on account of my injuries sustained on (date of occurrence) _____ and in payment of professional services rendered by Health Care Provider giving ad granting unto Health Care Provider said attorney full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully, to all intents and purposes, as I might or could do if personally present, with full power of substitution and revocation, hereby ratifying and confirming all that Health Care Provider, said attorney or his substitute shall lawfully do or cause to be done by virtue hereof.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the _____ day of _____, (month) in the year _____. (year)
Sealed and delivered in the presence of

_____ _____
Witness Patient's Signature

_____ _____
Print Name Print Patient's Name

_____
Witness

_____
Print Name

STATE OF FLORIDA
SS.
COUNTY OF PALM BEACH

I HEREBY CERTIFY, that on this day before me an officer authorized to take acknowledgements, personally appeared (patient) _____ to me well known, and acknowledged that he/she executed the foregoing Power of Attorney thereunto duly authorized.

I FURTHER CERTIFY, that the person making this acknowledgement is to me well known to be the person described in and who presented his/her driver's license bearing license number: FLA#_____

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid, this the _____day of _____(month) A.D. _____. (year)

_____
Notary Public in and for the
State of Florida

My Commission Expires: _____
Print Name

NOTICE OF DOCTOR'S LIEN

TO: Attorney `_____

_____

_____

Doctor:_____

RE: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay to said doctor such sums as may be due and owing him/her for medical services rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorneys fees, and/or court costs will be added to the total amount due.

Date_____

Dated: _____ Patient's Signature _____

Witness: _____ Address: _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court cost.

Dated: _____ Attorney's Signature _____

Attorney: Please date, sign and return one copy to above doctor's office at once.
Reply envelope attached.
Keep one copy for your records.
(Updated)

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_____

PERSONAL INJURY/WORKERS' COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words: _____

_____

_____

What was your position in car? ☐ Driver ☐ Passenger If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your car struck by other vehicle? ☐ Yes ☐ No

Was the impact from: ☐ the front? ☐ from the right side? ☐ from the left side? ☐ from the rear?

At the time of impact were you: ☐ looking straight ahead? ☐ looking right? ☐ looking left?

Were both hands on steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No Were you braced for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window

Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head

Immediately following the accident how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to hospital? ☐ Yes ☐ No

If you went to hospital, when? At time of accident ☐ Yes ☐ No Next day ☐ Yes ☐ No

How did you get to hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck Collar ☐ Yes ☐ No Splints: ☐ Yes ☐ No Brace: ☐ Yes ☐ No

Name of Hospital _____

Attended by Dr. _____ Were you x-rayed at hospital? ☐ Yes ☐ No

If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? ☐ Yes ☐ No See orthopedic doctor? ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name _____

Is your pain constant? ☐ Yes ☐ No Is the pain on and off? ☐ Yes ☐ No Sharp? ☐ Yes ☐ No Dull? ☐ Yes ☐ No

Other _____

Is your pain worse when arising from a chair? ☐ Yes ☐ No Is it made worse by straining? ☐ Yes ☐ No By coughing? ☐ Yes ☐ No

By sneezing? ☐ Yes ☐ No By straining when moving your bowels? ☐ Yes ☐ No

Do you have any numbness or tingling in your arms? ☐ Yes ☐ No In your hands? ☐ Yes ☐ No In your fingers? ☐ Yes ☐ No

In your legs? ☐ Yes ☐ No In your feet? ☐ Yes ☐ No In your toes? ☐ Yes ☐ No

What is your most comfortable position? Sitting ☐ Yes ☐ No Lying on your right side ☐ Yes ☐ No Lying on your left side ☐ Yes ☐ No

Lying on your back ☐ Yes ☐ No On your stomach ☐ Yes ☐ No Standing ☐ Yes ☐ No

Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve your pain? ☐ Heating Pad ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (if you have tried one) help relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you feel better moving around? ☐ Yes ☐ No Or resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in your leg? ☐ Yes ☐ No

In arm? ☐ Yes ☐ No Have you had any change in your bowel habits? ☐ Yes ☐ No

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

1. How much weight? ☐ Maximum ☐ Average
2. How far could you carry this weight? _____ For how long a period of time? _____
3. Was this lifting done at work? ☐ Yes ☐ No Or at home or elsewhere? ☐ Yes ☐ No
4. How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? _____
2. Did you experience this pain, discomfort or restriction of motion before your accident? ☐ Yes ☐ No
3. How far can you carry this weight now? _____ And for how long a period of time? _____
4. How often can you carry this weight? _____
5. Are you now limited in your lifting ability in some body position that you were previously not? ☐ Yes ☐ No
   If so, specify position _____
6. What symptoms does lifting produce? _____
7. How long do these symptoms last? _____

Are you presently able to:

LIFT	☐ Very Heavy _____ lbs.	☐ Heavy _____ lbs.	☐ Light _____ lbs.	☐ Sitting _____ lbs.
WORK	☐ Very Heavy _____ lbs.	☐ Heavy _____ lbs.	☐ Light _____ lbs.	☐ Sitting _____ lbs.

What positions can you work in with a MINIMUM DEMAND of physical effort?

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

☐ Standing ☐ Walking ☐ Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

☐ Yes ☐ No

Do you feel that you cannot perform any physical work activity? ☐ Yes ☐ No

Do you feel that you cannot perform any mental work? ☐ Yes ☐ No

Relate your BEFORE injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing activities:

1. Walking	Normal _____	Limited _____	Difficult _____	Pain _____
2. Standing	Normal _____	Limited _____	Difficult _____	Pain _____
3. Sitting	Normal _____	Limited _____	Difficult _____	Pain _____
4. Bending	Normal _____	Limited _____	Difficult _____	Pain _____
5. Stooping	Normal _____	Limited _____	Difficult _____	Pain _____
6. Lifting	Normal _____	Limited _____	Difficult _____	Pain _____
7. Pushing	Normal _____	Limited _____	Difficult _____	Pain _____
8. Pulling	Normal _____	Limited _____	Difficult _____	Pain _____
9. Climbing	Normal _____	Limited _____	Difficult _____	Pain _____
10. Reaching	Normal _____	Limited _____	Difficult _____	Pain _____
11. Gripping	Normal _____	Limited _____	Difficult _____	Pain _____
12. Kneeling	Normal _____	Limited _____	Difficult _____	Pain _____
13. Balance	Normal _____	Limited _____	Difficult _____	Pain _____
14. Fatigue	Normal _____	Limited _____	Difficult _____	Pain _____

Generally speaking, is your inability to perform these functions due to ☐ Pain ☐ Weakness ☐ Structural limitations ☐ Nerves?

Do you have normal sexual function? ☐ Yes ☐ No

Are you able to take care of your personal self, such as dressing, bathing, etc.? ☐ Yes ☐ No Or do you require assistance? ☐ Yes ☐ No

Do you feel your present condition is temporary? ☐ Yes ☐ No Or permanent? ☐ Yes ☐ No

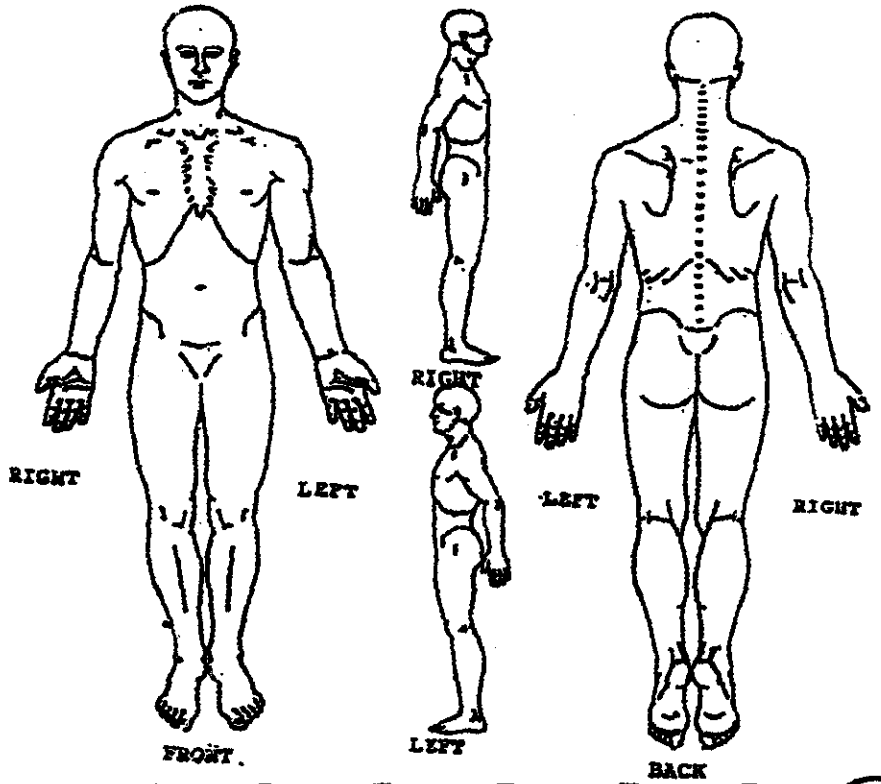
Patient's Signature _____ Date: _____

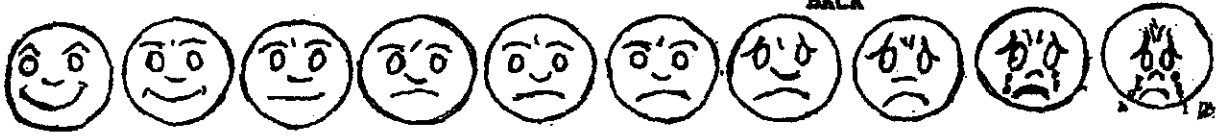
PAIN CHART

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 appetite suppressants, vitamins, herbal supplements, or any homeopathic medication:

_____

_____

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.

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

CERTIFIED MAIL RECIEPT #_____

DATE: _____

INSURANCE COMPANY NAME AND ADDRESS:

NAME: _____

ADDRESS: _____

SUITE #: _____

CITY: _____ STATE _____ ZIP _____

NOTICE OF INITIATION OF TREATMENT

PATIENT: _____

INSURED: _____

CLAIM NUMBER: _____

POLICY NUMBER:_____

Ladies and Gentlemen:

Please be advised that I have been consulted by and have rendered treatment to the above referenced patient, with the patients first date of treatment occurring on _____.

Also enclosed please find an assignment of benefits form to which the patient directed you to send all payments for services rendered to the undersigned.

In accordance with Flordia Statue 627.736(5)(b), I will be timely submitting the bills for this patient.

Sincerely,

MICHAEL PAPA, D.C, P.A. ☐

JUPITER WEST MEDICAL CENTER ☐

Dr. Michael Papa DC

AUTHORIZED REPRESENTATIVE_____