Automobile Accident Questionnaire

Please answer all questions completely

Dear patient: this information is considered confidential. We need this information to better understand the events surrounding your unfortunate trauma, and your answers will help us determine if chiropractic care can help you. In order for us to understand your condition, please be as accurate as possible. Thank you.

NAME: _____ DATE: _____

Accident Information:

Date of Accident: _____ City of Accident: _____

Accident Description:

1. Position in Vehicle

□ Driver □ Left Rear
□ Front Passenger □ Right Rear

2. Type of Vehicle

□ Car □ StationWagon
□ Van □ Pickup Truck
□ Bus □ Large Truck

3. What was your vehicle doing?

□ **Stopped** □ Intersection □ in traffic □ at Light
□ Turning □ right □ Left □ Parking
□ Proceeding along □ Slowing down □ Accelerating

4. Point of impact

□ Head-on
□ Rear-end
□ Right Side (Passenger) □ Left Side (Driver)

5. Details of Accident

Did you have a seat belt on? □ Yes □ No
Does your vehicle have airbags? □ Yes □ No
Did your airbag deploy? □ Yes □ No
Did you lose consciousness? □ Yes □ No

Where the Police at the scene? □ Yes □ No **Police Report:** □ Yes □ No (If yes, please provide us with a copy)

Additional Description:

Immediately Following the Accident:

Immediate Symptoms: □ No immediate symptoms □ Headache □ Dizziness □ Neck Pain □ Shoulder Pain
□ Arm Pain □ Low Back Pain □ Mid Back Pain □ Buttock Pain □ Leg Pain
□ **Numbness** in ○ Right Arm/Hand ○ Left Arm/Hand ○ Right Leg/Foot ○ Left Leg/Foot

Other: _____

Where did you go after the accident? □ Hospital □ Home □ Work □ Doctor □ Other

How did you get there? □ Ambulance □ Someone else □ Drove yourself

Hospital Visit Information: Hospital Name: _____ Date _____

Where you Admitted? □ Yes □ No Admission Date: _____

Services Received: □ X-rays Region of x-ray: _____

□ Medication Type of medication: _____

□ Recommendations: _____

Doctor Visit Information: Doctor's Name: _____ Date _____

Services Received: □ X-rays Region of x-ray: _____

□ Medication Type of medication: _____

□ Recommendations: _____

Other: _____

Since the Accident **Patient:** _____ **Date:** _____

Symptoms:

◻ Headache	◻ Head is heavy	◻ Dizziness	◻ Buzzing in ears	◻ Diarrhea
◻ Upset stomach	◻ Pins/needles in arms	◻ Eyes sensitive to light	◻ Loss of memory	◻ Cold feet
◻ Neck pain	◻ Problems sleeping	◻ Irritability	◻ Ringing in ears	◻ Cold hands
◻ Neck stiffness	◻ Pins/needles in legs	◻ Cold sweats	◻ Loss of balance	◻ Mid back pain
◻ Fainting	◻ Numbness in fingers	◻ Depression	◻ Constipation	◻ Low back pain
◻ Flushed face	◻ Numbness in toes	◻ Fatigue	◻ Loss of smell	◻ Tension
◻ Nervousness	◻ Shortness of breath	◻ Chest pain	◻ Loss of taste	◻ Fever

◻ Other: _____

Where you seen by another Doctor? ◻ Yes ◻ No

Name of Doctor: _____ Date of visit: _____ # of visits: _____

Services Rec. ◻ Evaluation ◻ X-rays ◻ Medication ◻Cervical Collar ◻ Back Brace ◻ Physical Therapy ◻ Chiropractic

X-rays Taken: ◻ Dr's office ◻ Hospital ◻ Radiology Ctr. Date of X-rays: _____

X-ray region: ◻ Head ◻ Neck ◻ Mid Back ◻ Chest ◻Low Back ◻ Arms ◻ Legs

Medication: ◻ Pain killers ◻ Muscle relaxers ◻ Over the counter medication (Advil, Tylenol etc.)

Treatments: ◻ Physical Therapy ◻ Chiropractic ◻ Pain Management ◻Other: _____

Diagnosis: ◻ Sprain/Strain ◻ Sciatica ◻ Disc Herniation ◻ Contusion ◻ Fracture ◻ Other:_____

Recommended: ◻ Ice/Heat ◻ Medication ◻ Referral to: _____

Other: _____

Have you ever had complaints in the involved areas before? ◻ Yes ◻ No

Have you ever had prior treatment for any same or similar condition? ◻ Yes ◻ No

Before the accident were you capable of working on an equal basis with others your age? ◻ Yes ◻ No

Are your work or daily activities restricted as a result of this accident? ◻ Yes ◻ No

Since the injury are your symptoms ◻ Improving? ◻ Getting worse? ◻ Same?

Other Notes:

I understand and agree that health and accident policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assisting in making collection from the insurance company and that any amount authorized to be paid to directly to this Chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT FORM

(TWENTY ONE DAY NOTICE)
(N.J.A.C. 11:3-25, et seq)

TREATING HEALTH CARE PROVIDER INFORMATION:

NAME: BRUNSWICK CHIROPRACTIC CENTER OF NJ, LLC
PROVIDER: Ivan B. Kosin, DC/ Neil I. Kosin, DC
ADDRESS: 1594 Route 130
North Brunswick, NJ 08902
PHONE: 908-753-5454 FAX: 732-821-7580

PATIENT INFORMATION:

NAME: _____
ADDRESS: _____
_____

INSURED INFORMATION (IF DIFFERENT THAN PATIENT):

NAME: _____
ADDRESS: _____
_____

INSURER INFORMATION:

NAME: _____
ADDRESS: _____
_____

POLICY NUMBER: _____
CLAIM NUMBER: _____
DATE OF ACCIDENT: _____
FIRST TREATMENT DATE: _____

ASSIGNMENT OF PIP MEDICAL BENEFITS FORM

PATIENT AUTHORIZATION:

I am the Patient described above and I authorize and direct the Insurer described above to pay the Treating Health Care Provider described above, the amount due under the terms of the policy described above for any PIP medical benefits rendered by the Treating Health Care Provider described above and/or all staff associated with that office.

I further authorize the Treating Health Care Provider described above to file a Demand For Arbitration (PIP) against the Insurer described above for any Payment Dispute for PIP medical benefits rendered by the Treating Health Care Provider described above and/or all staff associated with that office.

Payment Dispute shall include a denial and/or non-payment by the Insurer described above for PIP medical benefits rendered by the Treating Health Care Provider described above and/or all staff associated with that office. Payment Dispute shall also include a denial and/or refusal to authorize by the Insurer named above any recommended medical benefits

as part of the Treatment Plan of the Treating Health Care Provider described above and/or all staff associated with that office.

Release For Medical Records: It is understood that certain privacy rights attach to my medical records as created by federal and/or state legislative bodies and/or federal and/or state regulatory bodies. In order to prove the medical necessity, reasonableness and/or causal relationship of the treatment rendered to me, and/or proposed to be rendered to me, I authorize release of the medical records to the assignee and/or its agents as necessary for any Demand For Arbitration (PIP). A photocopy of this document shall serve as an original.

Release for IME Report: I authorize the Release of any IME Report and/or any Paper Review, prepared by any examining doctor, and/or any reviewing Medical Director, shall be released to my Treating Health Care Provider described above.

_____

Patient

TREATING HEALTH CARE PROVIDER REPRESENTATION:
I am the Treating Health Care Provider described above and provide the following representations to the Insurer named above in order for the Assignment of Benefits executed by the Patient named above to be honored. Specifically:

- All requirements of the Decision Point Review Plan and/or Pre Certification Plan of the Insurer named above that are in accordance with the regulations promulgated by the Department of Banking and Insurance (DOBI) shall be complied with; and
- In the event of a failure to comply with the aforementioned requirements, the Patient described above will not be held financially liable for any additional imposed penalty; and
- In the event of any dispute with the Insurer, resolution of the dispute shall be adjudicated by the filing of a Demand For Arbitration (PIP) through the administrator appointed by DOBI.

It is understood that an Insurer may apply to DOBI pursuant to N.J.A.C. 11:3-4.9 (a) for "approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage." As such, please provide me within ten days of receipt of this Form with any documentation required to effectuate the intent of the Patient described above. Failure to provide any documentation will be construed as a constructive acceptance of this Form and the intent of the Patient described above.

_____

Ivan B. Kosin, DC or Neil I. Kosin, DC

Registration Form

Please complete this form, print it out and bring to your appointment.

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP:

DATE OF BIRTH _____ HOME PHONE: _____ CELL PHONE: _____

AGE: ____ MARITAL STATUS: _____ SOCIAL SECURITY # _____

EMPLOYER: _____ ☐ FULL TIME ☐ PART TIME

ADDRESS: _____

WORK PHONE: _____ E-MAIL: _____

OCCUPATION: _____ DRIVERS LIC. #: _____

How did your hear about our office? _____

SPOUSE/EMERGENCY CONTACT: _____

ADDRESS: _____ HOME PHONE: _____

RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

PRIMARY MD NAME: _____ PHONE #: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT –LIST MOTOR VEHICLE INS. FIRST)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SEC. INSURANCE)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

Check If Applicable: ☐ Motor Vehicle Accident ☐ Work Injury Date of Accident: _____

CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____ Date: _____

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: _____

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:_____
_____
_____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer –Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

FAMILY MEDICAL HISTORY:

Mother:	Age: _____	( ) Living	( ) Deceased
Father:	Age: _____	( ) Living	( ) Deceased
Siblings:	Age: _____	( ) Living	( ) Deceased

Please check each box with if any family member (mother, father or siblings) has had any of the following:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer –Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

CURRENT MEDICATIONS: Please list all current medications below or provide us with a list of medications

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____

( ) Tobacco ( ) Type: _____ ( ) Alcohol Type: _____
( ) Year begun: _____ How often: _____
( ) Still smoking How much: _____
( ) Year quit: _____ How many years: _____
( ) Packs per day: _____

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other: _____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL:	□ Weight gain	□ Weight loss	□ Fever	□ Hair loss
	□ Weakness	□ Other: _____		
EYES:	□ Eye strain	□ Wear glasses or contact lenses		□ Sensitivity to light
EAR, NOSE,THROAT	□ Ringing in ears	□ Hearing loss	□ Discharge or pain	□ Dizziness
	□ Runny nose	□ Difficulty breathing through nose		□ Sinusitis
	□ Painful teeth, gums, or palate		□ Growths in the mouth	
	□ Pain or difficulty swallowing		□ Hoarseness	
CARDIOVASCULAR	□ Palpitations	□ Chest pain	□ Fainting	□ Dizziness
	□ Varicose veins	□ Difficulty climbing Stairs		□ Pain in the legs
	□ Cold Feet/Hands		□ Shortness of breath	
RESPIRATORY	□ Shortness of breath while walking		□ Cough with or without phlegm	
	□ Asthma/Wheezing		□ Spit up blood	
	□ Other: _____			
GASTROINTESTINAL	□ Abdominal pain	□ Nausea	□ Vomiting	□ Diarrhea
	□ Hemorrhoids	□ Change in shape or color of stool		
GENITOURINARY	□ Discharge	□ Pain	□ Frequent urination	□ Pain with urination
MUSCULOSKELETAL	□ Weakness	□ Back Pain	□ Neck Pain	□ Leg Pain
	□ Arm Pain	□ Shoulder Pain	□ Numbness	□ Headaches
	□ Other: _____			
SKIN	□ Jaundice	□ Dry skin	□ Pigment Change	□ Growths
	□ Moles that have changed color, shape, or bleed			
NEUROLOGIC	□Tremors	□ Weakness	□ Numbness	□ Memory Loss
	□ Confusion	□ Other: _____		

INITIAL CONSULTATION FORM

NAME: _____ DATE: _____

Dominant Hand ☐ Right ☐ Left ☐ Both

☐ Initial Examination ☐ Re-examination ☐ Update ☐ Discharge Examination

Description/Onset: _____

PRESENTING CONDITION

Primary Complaint: _____

Date of Onset: _____ Type of Onset: ☐ Sudden ☐ Gradual ☐ Traumatic ☐ Chronic ☐ Unknown

Type of Pain: ☐ Dull Ache ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Throbbing ☐ Burning

Pain Frequency: ☐ Constant (76-100% of the day) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (0-25%)

Pain Intensity: ☐ Minimal ☐ Slight ☐ Mild ☐ Mild/Mod ☐ Moderate ☐ Mod/Severe ☐ Severe

Pain Rating (1-10): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Radiation: ☐ Head __ ☐ Neck__ ☐ Shoulder __☐ Arm __ ☐ Hand _☐ Buttock __ ☐ Hip___ ☐ Thigh__☐ Leg__☐ Foot___

Aggravated by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Cough/Sneezing ☐ Stress ☐ Walking

Relieved by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Nothing

Affects: ☐ Work ○ Disabled ○ Partial ○ Limited ☐ Personal Care ☐ Social Life ☐ ADL's Rate: _____(1-10)

Explain: _____

Second Complaint: _____

Date of Onset: _____ Type of Onset: ☐ Sudden ☐ Gradual ☐ Traumatic ☐ Chronic ☐ Unknown

Type of Pain: ☐ Dull Ache ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Throbbing ☐ Burning

Pain Frequency: ☐ Constant (76-100% of the day) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (0-25%)

Pain Intensity: ☐ Minimal ☐ Slight ☐ Mild ☐ Mild/Mod ☐ Moderate ☐ Mod/Severe ☐ Severe

Pain Rating (1-10): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Radiation: ☐ Head __ ☐ Neck__ ☐ Shoulder __☐ Arm __ ☐ Hand _☐ Buttock __ ☐ Hip___ ☐ Thigh__☐ Leg__☐ Foot___

Aggravated by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Cough/Sneezing ☐ Stress ☐ Walking

Relieved by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Nothing

Affects: ☐ Work ○ Disabled ○ Partial ○ Limited ☐ Personal Care ☐ Social Life ☐ ADL's Rate: _____(1-10)

Explain: _____

Third Complaint: _____

Date of Onset: _____ Type of Onset: ☐ Sudden ☐ Gradual ☐ Traumatic ☐ Chronic ☐ Unknown

Type of Pain: ☐ Dull Ache ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Throbbing ☐ Burning

Pain Frequency: ☐ Constant (76-100% of the day) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (0-25%)

Pain Intensity: ☐ Minimal ☐ Slight ☐ Mild ☐ Mild/Mod ☐ Moderate ☐ Mod/Severe ☐ Severe

Pain Rating (1-10): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Radiation: ☐ Head __ ☐ Neck__ ☐ Shoulder __☐ Arm __ ☐ Hand _☐ Buttock __ ☐ Hip___ ☐ Thigh__☐ Leg__☐ Foot___

Aggravated by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Cough/Sneezing ☐ Stress ☐ Walking

Relieved by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Nothing

Affects: ☐ Work ○ Disabled ○ Partial ○ Limited ☐ Personal Care ☐ Social Life ☐ ADL's Rate: _____(1-10)

Explain: _____

Additional Complaints: _____

Past History of Condition (s) _____

Doctors seen for this treatment: _____ Date of Last Visit: _____

What treatment did you receive/ results? _____

What test have you had for this condition? ☐ X-rays ☐ MRI ☐ CT Scan ☐ Other: _____

Comments: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FROM PRIVATE HEALTH GROUP AND/OR ACCIDNET INSURANCE

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed directly to:

BRUNSWICK CHIROPRACTIC CENTER OF NEW JERSEY, LLC
1594 ROUTE 130 NORTH
NORTH BRUNSWICK, NJ 08902
TAX ID# 90-0672418

If my current policy prohibits direct payment to the doctor, I hereby recognize I am financially responsible for payment of all services to me at the **Brunswick Chiropractic Center of New Jersey, LLC.** I also understand I am responsible to bring my payments received from my insurance company, along with the accompanying explanation of benefits form attached to the check for services rendered to me at the **Brunswick Chiropractic Center of New Jersey, LLC.**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional services charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor and/or attorney involved in this case.

I also authorize the Brunswick Chiropractic Center of New Jersey, LLC to disclose in narrative format or any other format, the results of any permanency and impairment rating evaluation. I completely understand, this is a comprehensive medical picture and may be submitted for administrative and judicial opinions.

Dated this ___day of _____, 2012

_____
Signature of patient/policyholder/claimant

_____
Signature of witness

PATIENT REQUEST FOR RECORDS

DATE: _____

TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby authorize the release of my_____ or copies of such and request that thery be transferred to:

BRUNSWICK CHIROPRACTIC CENTER OF NJ, LLC
1594 ROUTE 130
NORTH BRUNSWICK, NJ 08902
(908) 753-5454
FAX: (732) 821 7580

_____ _____
Patients Name **Social Security Number**

_____ _____
Address **Date of Birth**

_____ _____
City, State and Zip Code **Date of Records**

_____ _____
Patient's Signature **Date of Accident**

CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____ Date: _____

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: _____

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:_____
_____
_____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer – Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

FAMILY MEDICAL HISTORY:

Mother: Age: _____ ( ) Living ( ) Deceased
Father: Age: _____ ( ) Living ( ) Deceased
Siblings: Age: _____ ( ) Living ( ) Deceased

Please check each box with if any family member (mother, father or siblings) has had any of the following:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer – Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis

□ Ulcer □ Varicose Veins □ Other: _____

CURRENT MEDICATIONS: Please list all current medications below or provide us with a list of medications

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____

( ) Tobacco ( ) Type: _____ ( ) Alcohol Type: _____
( ) Year begun: _____ How often: _____
( ) Still smoking How much: _____
( ) Year quit: _____ How many years: _____
( ) Packs per day: _____

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other:_____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: _____

EYES: □ Eye strain □ Wear glasses or contact lenses □ Sensitivity to light

EAR, NOSE,THROAT □ Ringing in ears □ Hearing loss □ Discharge or pain □ Dizziness
□ Runny nose □ Difficulty breathing through nose □ Sinusitis
□ Painful teeth, gums, or palate □ Growths in the mouth
□ Pain or difficulty swallowing □ Hoarseness

CARDIOVASCULAR □ Palpitations □ Chest pain □ Fainting □ Dizziness
□ Varicose veins □ Difficulty climbing Stairs □ Pain in the legs

	□ Cold Feet/Hands		□ Shortness of breath	
RESPIRATORY	□ Shortness of breath while walking		□ Cough with or without phlegm	
	□ Asthma/Wheezing		□ Spit up blood	
	□ Other: _____			
GASTROINTESTINAL	□ Abdominal pain	□ Nausea	□ Vomiting	□ Diarrhea
	□ Hemorrhoids	□ Change in shape or color of stool		
GENITOURINARY	□ Discharge	□ Pain	□ Frequent urination	□ Pain with urination
MUSCULOSKELETAL	□ Weakness	□ Back Pain	□ Neck Pain	□ Leg Pain
	□ Arm Pain	□ Shoulder Pain	□ Numbness	□ Headaches
	□ Other: _____			
SKIN	□ Jaundice	□ Dry skin	□ Pigment Change	□ Growths
	□ Moles that have changed color, shape, or bleed			
NEUROLOGIC	□Tremors	□ Weakness	□ Numbness	□ Memory Loss
	□ Confusion	□ Other: _____		

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Brunswick Chiropractic Center of New Jersey, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Brunswick Chiropractic Center of New Jersey, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Brunswick Chiropractic Center of New Jersey, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Brunswick Chiropractic Center of New Jersey, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

Registration Form

Please complete this form, print it out and bring to your appointment.

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:

DATE OF BIRTH _____ HOME PHONE: _____ CELL PHONE: _____

AGE: _____ MARITAL STATUS: _____ SOCIAL SECURITY # _____

EMPLOYER: _____ ☐ FULL TIME ☐ PART TIME

ADDRESS: _____

WORK PHONE: _____ E-MAIL: _____

OCCUPATION: _____ DRIVERS LIC. #: _____

How did your hear about our office? _____

SPOUSE/EMERGENCY CONTACT: _____

ADDRESS: _____ HOME PHONE: _____

RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

PRIMARY MD NAME: _____ PHONE #: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT –LIST MOTOR VEHICLE INS. FIRST)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SEC. INSURANCE)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

Check If Applicable: ☐Motor Vehicle Accident ☐ Work Injury Date of Accident: _____