SCOMA CHIROPRACTIC P.A.

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HEALTH AND WELLNESS CENTER

MAJOR MEDICAL/MEDICARE

DATE_____

PLEASE PRINT

FIRST NAME_____M.I._____LAST NAME_____NICKNAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

SS#_____PH (HM)_____(WK)_____(CELL)_____

DATE OF BIRTH_____AGE_____M___F___ MARTIAL STATUS: __M__ S__ D__ W

EMPLOYER /SCHOOL_____ PREVIOUS CHIROPRACTIC? ____WHEN___

E-MAIL_____

PRIMARY PHYSICIAN_____LAST SEEN _____REASON_____

PHONE #_____

POLICY HOLDER'S NAME_____DOB_____SS#_____

DESCRIBE CURRENT REASON WHY YOU ARE HERE-BE SPECIFIC

A. HOW DID THIS INJURY HAPPEN? __WORK__CAR___HOME___OTHER

B. CURRENT COMPLAINT & HOW DID IT HAPPEN?_____

_____

C. WHEN DID IT BEGIN TO HURT?_____

D. WHAT INCREASES THE PAIN?_____

E. WHAT MAKES IT FEEL BETTER?_____

F. WHAT DOES THE PAIN OR DISCOMFORT FEEL LIKE? (ACHE, SHARP, DULL, HOT, ETC)

_____

G.DOES THE PAIN OR DISCOMFORT TRAVEL IF SO TO WHERE?

_____

PLEASE CIRCLE YES OR NO

FAMILY HISTORY:

DIABETES Y N STROKE/HEART Y N CANCER Y N OTHER_____

SOCIAL HISTORY:

CURRENT OCCUPATION_____

HOBBIES/INTERESTS_____

HAVE YOU EVER SMOKED? Y N IF YES HOW MUCH_____QUIT(WHEN)_____

DO YOU DRINK Y N HOW MUCH_____

PAST MEDICAL HISTORY:

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N WHAT_____

1. PAST ILLNESSES_____

2. PAST OPERATIONS_____

3. PAST INJURIES_____

4, PAST TREATMENTS_____

CURRENT MEDICATIONS:_____

_____

PLEASE LIST ANY DISORDER OR MEDICAL CONDITION NOT LISTED BELOW:

_____

REVIEW OF SYSTEMS

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE LIST YEAR ALSO

ENDOCRINE:

DIABETES Y N WHEN_____ THYROID Y N WHEN_____

CARDIOVASCULAR:

HIGH BLOOD PRESSURE Y N WHEN_____ HEART ATTACK Y N WHEN_____

BYPASS SURGERY Y N WHEN_____ CONGESTIVE HEART Y N WHEN_____

IRREGULAR BEAT Y N WHEN_____ CHEST PAINS Y N WHEN_____

RESPIRATORY:

LUNG DISEASE Y N WHEN_____ ASTHMA Y N WHEN_____ EMPHYSEMA Y N WHEN__

SHORTNESS BREATH Y N WHEN_____

GASTROINTESTINAL:

ULCERS Y N WHEN_____ COLITIS Y N WHEN_____ IBS Y N WHEN_____

ACID REFLUX Y N WHEN_____ LIVER DISEASE Y N WHEN_____

BOWEL CHANGES OR PROBLEMS Y N WHEN_____

MUSCULAR/SKELETAL:

ARTHRITIS Y N WHEN_____ MUSCLE PROBLEMS Y N WHEN_____

NAME:_____ DATE_____

NEURLOGICAL:

NEUROLOGICAL Y N WHEN_____ STROKE Y N WHEN_____ PARALYSIS Y N WHEN____
NUMBNESS/TINGLING Y N WHEN____ DIZZINESS/VERTIGO Y N WHEN_____

URINARY:

STONES Y N WHEN_____ FAILURE Y N WHEN_____ TROUBLE URINATING Y N WHEN____

SKIN:

RASHES Y N WHEN_____ SKIN CANCER Y N WHEN_____

HEMATOLOGICAL:

BLOOD DISORDER Y N WHEN_____ BLOOD TRANSFUSION Y N WHEN_____

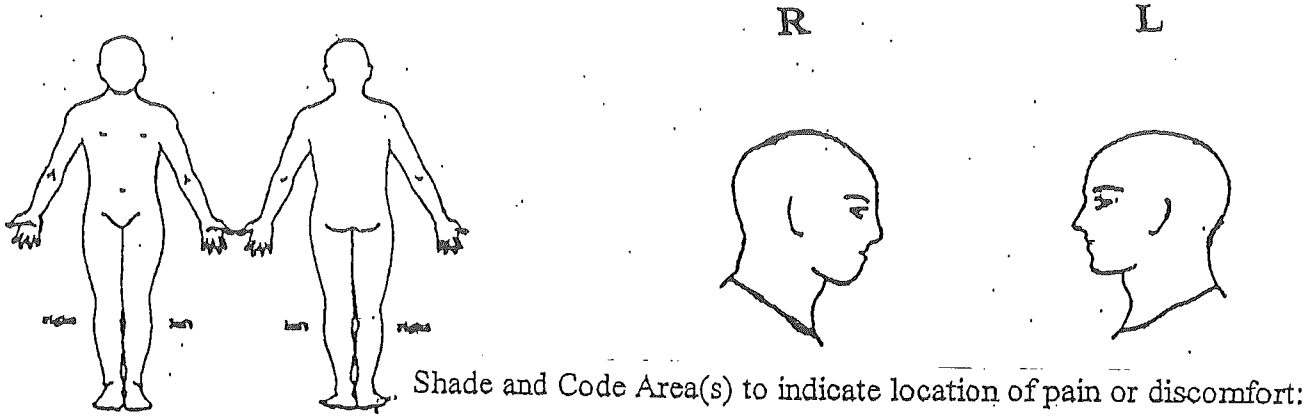
EENT:

RINGING EARS Y N WHEN_____ TROUBLE HEARING Y N WHEN_____

CONSTITUTION :

ORGAN TRANSPLANT Y N WHEN_____ INFECTIOUS DISEASE Y N WHEN_____
MENTAL ILLNESS Y N WHEN_____

Use Codes: ST- Stiffness N – Numbness S – Spasm T – Tenderness T/B- Tingle/Burn
A- Ache SP- Sharpness



Shade and Code Area(s) to indicate location of pain or discomfort:

RATE YOUR PAIN: 1- 10 (1-3 MINIMAL,SLIGHT 4-6, MODERATE 7-9, MARKED 10) CIRCLE
1 2 3 4 5 6 7 8 9 10

****Please read the following and sign below, indicating you fully understand the information.**
I fully understand that any insurance benefits explained to me are not a guarantee of payment. These benefits, which have been explained to me, are based solely upon information that my insurance company possessed at the time benefits were verified, and the actual payment will be based upon my plan provisions. I also understand that I am responsible for any services that my insurance company may deem NOT MEDICALLY NECESSARY or REIMBURSABLE. By Florida Law insurance companies must pay claims within 45 days however due to Insurance companies failure to comply resulting from their use of stall tactics we will only bill you insurance once. We will bill your insurance company with a complete and correct claim form. Beyond 45 days the full balance is your responsibility. Your payment is then expected within 10 days of notification from this office. If we do receive additional payment from your insurer, your account will be credited or a refund will be made to you. A $25.00 re-billing fee will be added to your account for each month that your account is unpaid and an interest charge of 18% per year or 1.5% per month will be added to the account, it may also be sent to small claims court. You will be responsible for all attorney costs should they arise.

_____
Patient's Signature

Patient name: _____ Date: _____