

LIVE PROPER HEALTH

Chiropractic & Weight Loss



Dear Valued Patient,

In order to best meet your healthcare needs, please take a moment to complete the attached forms. This information will give us a better understanding of your current health condition and is a vital component in order for us to deliver top quality healthcare to you. If you have questions, please contact our office.

Payment

We deliver high quality care and dedicated service at a price you can afford. Payment is expected at the time of your visit unless other arrangements have been made. Payment plans and financial hardship discounts are also available on request. We accept cash, checks, and some credit cards. Please make checks payable to Live Proper Health. Contact our staff with any questions about our payment policy and/or our office fees.

Health Insurance

If you have insurance, we will require a copy of your insurance card and driver's license. We recommend that you contact your insurance company to verify your benefits. Please understand that your insurance is a contract between you and your chosen insurance carrier. Restoring your health is our foremost objective. Our treatment will always be rendered solely on the basis of need. We require partial payment at the time of service unless special arrangements have been previously made. We cannot promise that an insurance company will pay for your care, even when it is preauthorized. We may be an out-of-network provider with your insurance carrier. We will submit bills to your insurance carrier, but will not become involved in disputes between the insured and the insurance company. If the insurance company erroneously pays directly to the insured, the amount shall be forwarded to this office within three days. You are ultimately responsible for office fees not covered by your insurance carrier. What you will receive from the Insurance Company is simply an Explanation of Benefits (EOB) AND NOT A BILL.

Missed Appointments

There is a \$40.00 charge for missed appointments without a 24 hour notice. This charge is the patient's responsibility and cannot be charged to the insurance company.

Patient Signature _____ Date _____

Welcome to our office!

Please take a moment to fill out these forms to allow us to better understand and care for your condition, Thank you!

PATIENT INFORMATION

Date: _____ Patient Name: _____ Sex: M F Age: ____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone:(____) _____ Cell Phone:(____) _____ Email: _____

Patient Employer/School: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer/School Phone:(____) _____ Ext: _____

Married Widowed Single Minor Separated Divorced Partnered for ____ Years

Spouse's Name: _____ DOB: _____ SS#: _____ Spouse's Employer: _____

EMERGENCY CONTACT INFORMATION: Name: _____ Relationship: _____

Home Phone:(____) _____ Cell Phone:(____) _____ Work Phone:(____) _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co. _____ ID # _____ Group # _____ Tel: (____) _____

Is patient covered by additional insurance? Yes No Subscriber's Name: _____ DOB: _____

SS#: _____ Relationship to Patient: _____ Insurance Co. _____ ID/Group #: _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No (if yes please notify our staff as other forms may need to be completed)

Date of accident: _____ Type of Accident: Auto Work Home Other: _____

Whom have you made a report of your accident? Auto Insurance Employer Worker Comp. Other

Attorney's Name (if applicable): _____ Phone:(____) _____

HEALTH HISTORY / SOCIAL HISTORY

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Spinal Exam: _____ Other: _____

Allergies: _____

Exercise: None Moderate Daily Heavy Other: _____

Habits: Smoking (____ packs/day) Alcohol (____ drinks/week) High Stress Level (Reason: _____)

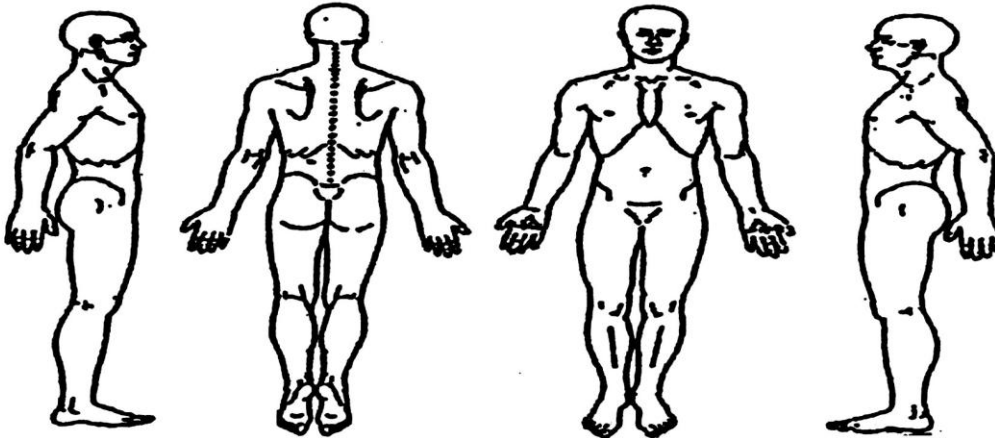
COMMENTS

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Briefly describe what brings you to our office today: _____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp
- Diffuse
- Burning
- Stiff
- Numb
- Sharp with motion
- Stabbing with motion
- Other: _____
- Dull
- Achy
- Shooting
- Tingly
- Shooting with motion
- Electric like with motion

5. How are your symptoms changing with time?

- Getting Worse
- Staying the Same
- Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

8. How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

9. Who else have you seen for your problem?

- Chiropractor
- ER physician
- Massage Therapist
- Neurologist
- Orthopedist
- Physical Therapist
- Primary Care Physician
- Other: _____
- No one

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe? Yes Yes, at times No

13. What aggravates your problem? _____

14. What alleviates your problem (makes it better)? _____

15. What concerns you the most about your problem; what does it prevent you from doing?

16. What is your: Height _____ Weight _____ Date of Birth _____ Occupation _____

17. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

18. What type of exercise do you do?

- Strenuous Moderate Light None

19. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus Heart Problems
 Cancer ALS Obesity Other _____

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Change	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Other _____

21. List all medications you are currently taking: _____

22. List all of the vitamins/supplements you are currently taking? _____

23. List all surgical procedures you have had (with dates): _____

24. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

25. What activities do you do outside of work? _____

26. Have you ever been hospitalized? No Yes

If yes, why _____

27. Have you been to a Chiropractor in the past? No Yes If yes, how long ago? _____

28. Have you had significant past trauma? No Yes

29. Anything else pertinent to your visit today? _____

30. What goals do you wish to achieve through care? _____

Patient Signature _____ Date: _____

CONSENT TO TREAT

Please read, sign, and date for all of the following:

Release of Records

I do hereby authorize Luke Pinatello D.C., P.C., to release my medical records and billing records to any of its billing companies, attorneys, adjusters, etc. for the purpose of getting my bill paid.

I do hereby authorize Luke Pinatello D.C., P.C., to release my medical records to my primary care physician and/or any other healthcare provider co-managing my current condition, as they deem necessary throughout the duration of my care.

Consent to Treat

I hereby authorize Luke Pinatello D.C., P.C., and their assistants to perform medical examination, physical therapy, spinal manipulation, and/or diagnostic testing to me today and at future office visits.

Financial Agreement

I have been advised by Luke Pinatello D.C., P.C., that my co-payment or co-insurance will be collected on each visit. I also understand that if I am not able to afford my entire co-pay or co-insurance, special arrangements may be made for me. However, it is my responsibility to notify Luke Pinatello D.C., P.C., of my situation.

Assignment of Benefits

I understand that my insurance company may not accept assignment. I understand that my insurance company will pay me directly for the services rendered to me from Luke Pinatello D.C., P.C., I also understand that I will receive check(s) from the insurance company made payable in my name to me directly. I also understand that it is my responsibility to forward these checks and explanation of benefits to Luke Pinatello D.C., P.C., immediately upon receipt. I understand that it is illegal for me to cash or deposit the insurance checks that I will receive for services from this provider particularly when I have not paid for the services personally. I understand that if I fail to forward the check for these services, it will be my responsibility to pay my balance in full for all services provided to me. I know I will be given five business days to settle my account before legal proceedings begin. If my account is not settled I will also be responsible for any additional costs, such as court costs and legal fees. I understand that services provided to me today may be issued on more than one check, and I agree to forward all checks regarding today's treatment to Luke Pinatello D.C., P.C. I willingly sign this agreement.

Limited Power of Attorney

I expressly authorize and give power of attorney to Luke Pinatello D.C., P.C., and their billing agents for the signing and completing of any form in the completion of my claims and endorsing any check made payable to me, in support of processing or making payment of a claim for any charges incurred by me at this office. Further, these offices acknowledge that it is only entitled to receive payment for those charges, which were incurred through this office and any overpayment will be refunded appropriately and timely.

Privacy Practices Acknowledgement

I have been offered / received a copy of the Notice of Privacy Practices provided by Luke Pinatello DC PC. I have been provided an opportunity to review it.

Print Name

Signature

Date

**Luke Pinatello DC PC
1010 East Main Street
Shrub Oak, New York 10588
914.214.8949
866.441.6581**

PATIENT PROGRESS NOTES FORWARDING

In an effort to work in cooperation with your other Health Care Providers, we will forward our progress notes to anyone you list below.

Please list your medical doctor(s) with corresponding address here:

Name: _____
Office: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Office: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Office: _____
Address: _____
Phone: _____
Fax: _____

Print Name

Signature

Date

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe _____
11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)
 - kept going straight - kept going straight hitting a car in front - was hit by another vehicle - hit a stationary object
 - spun around - spun around and hit a stationary object -other: _____
18. Did you lose consciousness during the accident? -yes - no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? -no - yes, please describe _____
23. Did your face hit anything during the accident? -no - yes, please describe _____
24. Did your shoulders hit anything during the accident? -no - yes, please describe _____
25. Did your neck hit anything during the accident? -no - yes, please describe _____
26. Did your chest hit anything during the accident? -no - yes, please describe _____
27. Did your hips hit anything during the accident? -no - yes, please describe _____
28. Did your knees hit anything during the accident? -no - yes, please describe _____
29. Did your feet hit anything during the accident? -no - yes, please describe _____
30. What kind of headrest was in your vehicle?
 - movable fixed headrest - nonmovable fixed headrest - no headrest
31. Where was the headrest positioned on your head? _____
32. Did you have your seatbelt on during the accident? - yes -no