ONONDAGA HILL CHIROPRACTIC, PLLC

NEW PATIENT FORM

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ Zip Code:_____

Social Security # _____/_____/_____ _____Male _____Female Smoker: Y N

Date of Birth:_____ Age:_____ Height:_____ Weight:_____lbs.

Marital Status: ___S ___M ___D ___W ___Other Spouse Name:_____

No. of Children:_____ Email:_____

Cell Phone #:( )_____ Home Telephone#:( )_____

Employer:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Work #:( )_____ Occupation:_____

Whom may we thank for referring you here? _____

INSURANCE INFORMATION:

Insurance Co._____ ID#_____ Group #_____

Subscriber:_____ Subscriber DOB:_____ Relationship:_____

CURRENT INFORMATION:

Describe your symptoms in detail:_____

_____

How and when did the problem start:_____

_____

Have you had a similar condition? _____ If so when:_____

Dr:_____

Is current condition due to an accident? _____ Yes _____ No Date:_____

Type of accident? _____Auto _____Work _____Home _____Other

A report of my accident has been given to: _____Auto Ins. _____Employer _____W/C _____Other

Rate your pain on a scale from **1 (least pain) to 10 (severe pain)** _____

Type of Pain:

_____sharp _____dull _____achy _____numbness _____burning

_____throbbing _____deep _____stiff _____tingling _____localized _____localized

Severity: 1. _____Mild _____Moderate _____Severe

2. _____Improving _____Persistent _____Worsening

3. _____Occasional _____Frequent _____Constant

Condition improves with:

____rest ____meds ____heat ____ice ____stretching ____standing ____sitting ____other

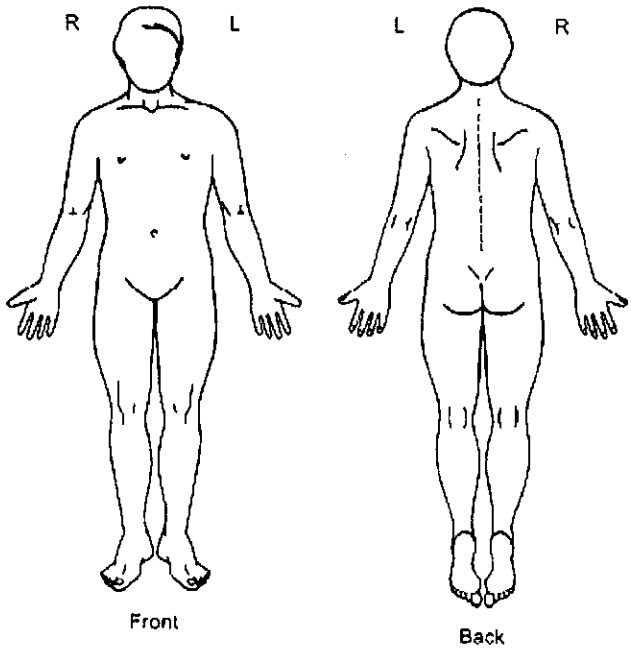
Condition is aggravated by:

____rest ____bending ____twisting ____general movements ____standing _____sitting

____coughing/sneezing ____other

Radiating/Does pain radiate? ____Yes ____No

Indicate symptoms with an X



Past Health History:

Significant injuries:_____

When, please describe:_____

HEALTH CONDITIONS: Please check all that apply and explain in appropriate area.

Constitutional:

____Fever ____Chronic Fatigue Syndrome ____Developmental problems ____Nutritional problems

Explain:_____

Neurological:

____Seizure ____Confusion ____Tremors ____Significant memory loss ____Swallowing difficulties

____Difficulties with speech

Explain:_____

Cardiovascular:

____Sharp chest pain ____Murmur ____Shortness of breath ____Palpitations

Explain:_____

Lymphatic: Pain in lymph nodes in: ____Arm pits ____groin ____other areas

Explain:_____

Integumentary (skin):

____Color change ____Lesions ____Skin cancer ____Rash ____Lumps ____Other

Do you experience pain every day?	____Yes	____No
Do your symptoms interfere with your daily life?	____Yes	____No
Does pain wake you up at night?	____Yes	____No
Are your symptoms worse during certain times of the day?	____Yes	____No
Do changes in weather affect your symtoms?	____Yes	____No
Do you take vitamin supplements?	____Yes	____No

Social History:	**Smoking**	**Alcohol**	**Caffeine**	**Exercise**
(Circle all	Never smoked	None	None	Never
that apply)	Current smoker	Casual	<3/day	Daily/Weekly
	Everyday	Moderate	3-6/day	Walks/Runs
	Former smoker	Heavy	>6/day	Swims

Onondaga Hill Chiropractic

4525 W. Seneca Turnpike

Syracuse, NY 13215

CONSENT TO USE PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Onondaga Hill Chiropractic, PLLC or may be disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____ Patient Initials

Requesting a Restriction on the Use of Disclosure of Your Information

*You may request a restriction on the use or disclosure of your Protected Health Information.

*This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

*If we agree to your request, the restriction will be binding with this office. Use or disclosure Of protected information in violation of an agreed upon restriction will be a violation of the Federal privacy standards,

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request.

Revocation of Consent

You may revoke this consent to use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Print Patient's Full Name Time

_____ _____

Witness Signature Date

ONONDAGA HILL CHIROPRACTIC
4525 W. Seneca Turnpike
Syracuse, NY 13215
315-469-7791
drancone@onondagahillchiro.com

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name _____ Signature _____ Date _____

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

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Patient Name: _____ File: _____

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Onondaga Hill Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visits may be denied and this may be beyond the office's ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

I understand this office will require payment from me for any services not covered by my health insurance plan.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Leonard Ancone.
I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

_____

Signature (Patient or Parent/Guardian of Patient) Date

Release of Medical Records:

I give my permission for Dr. Ancone to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition.

_____

Signature (Patient or Parent/Guardian of Patient) Date