BAYWEST MEDICAL, LLC - NEW PATIENT PAPERWORK

Patient Information

Please Print

Name_____ **Date**_____ **SS#**_____

Address_____**City**_____ **State**_____ **Zip**_____

Patient Email_____

Seasonal Address_____**City**_____ **State**_____ **Zip**_____

Male Female Married Single Widowed Divorced Separated

Birthdate_____ **Home Phone**_____ **Cell**_____

Work Phone_____ **Employer**_____

Occupation_____ **#years**_____

Spouse or Parent's Name_____ **Birthdate**_____ **Phone** _____

Emergency Contact_____**Phone** _____ **Relation**_____

Whom may we thank for referring you to us? _____

Did you find us online?_____

Name of local primary Physician_____ **May we contact them?**___

SYMPTOMS

Main Complaint_____ **How Bad?**_____ **How Often?**_____

When did it start?_____**Getting Worse?**_____**Getting Better?**_____

What activity bothers it the most? _____

When is it at its best?_____ **When is it at its worst?**_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ **Positive Experience?**_____

Other type of physician or therapist?_____ **Positive Experience?**_____

Secondary Complaint_____

Health History - Please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure	Fibromyalgia	Other_____				

Women - How many children?_____**Pregnant?**_____**Date of last Menstrual Cycle**_____

Nursing?_____**Taking Birth Control Pills?**_____

Previous Surgeries and Dates? _____

_____

List ALL Medications you are currently taking _____

_____

What kind of exercise do you do? _____

What supplements do you take?_____

How much do you smoke per day?_____ **Drink per week?** _____

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.**

Patient Signature_____ **Date**_____

SymptomSurvey

Please circle as many as apply

Patient Name _____ Date: _____

Head: **Headache Pain Level:** Mild Moderate Severe **How Often**: Daily _x Day _ x Week ____ x Month
Type of Pain: Sharp Dull **Frequency**: Constant Intermittent Staff Only
Location: Back of Head Forehead Temples Right Side Left Side Behind Eyes Frequency: %

Jaw: **Pain:** Right Left Both **Clicking/Popping:** Right Left Both Frequency: %

Neck: **Pain Location**: Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull
Pain Increased by: Forward Movement Backward Movement Rotate Head Right Rotate Head Left
Bending Head Left Bending Head Right Frequency: %

Shoulder: **Pain Location:** Right Left Both **Pain Level**: Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles**: Right Left Both Frequency: %

Upper Arm: **Pain Location**: Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Elbow: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Forearm: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Hand/Wrist: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles**: Right Left Both Frequency: %

Upper Back: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull Frequency: %

Middle Back: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull Frequency: %

Low Back: **Pain Location:** Right Left Both **Pain:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull
Pain Increased by: Forward Movement Backward Movement Rotate Torso Right Rotate Torso Left
Bending Torso Left Bending Torso Right

Hip: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Upper Leg: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Knee: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Lower Leg: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Ankle/Foot: **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe
Type of Pain: Sharp Stabbing Dull **Pins and Needles:** Right Left Both Frequency: %

Briefly describe how your daily activities have changed due to this injury? _____

Privacy Notice

(as required by HIPPA)

ALL CUSTOMER HEALTHCARE INFORMATION WILL BE KEPT PRIVATE

BAYWEST MEDICAL, **LLC may be required to use information in the following ways:**

- **T**reatment. We may utilize or possibly disclose your health information to your healthcare provider only in order to assist in our supplying of medical products and/or equipment and in the treatment of your condition.
- **P**ayment. We may be required to disclose your health information in order to collect payment from third parties for services rendered or supplies provided.
- **D**elivery Reminders. BAYWEST MEDICAL, LLC may need to use your personal information in order to be able to contact you.
- **R**elease of Information to Family/Friends. We may need to provide information to an Individual if you are being cared for by a family member or friend.
- **D**isclosures Required by Law. Our organization will disclose health information when we are required by federal state or local law.
- **P**ublic Health Risks, Health Oversight Activities, Workers Compensation.
- **L**awsuits Law Enforcement, Threats to Health and Safety, Military, National Security.

Your Rights Regarding Your Identifiable Health Information:

- **C**onfidential Communications. You have the right to request that our organization communicate with you about you and your health. In addition you may request that this communication take place in a confidential environment. This request must be given in writing.
- **R**equesting Restriction. You may request a restriction in the use or disclosure of your personal health information to individuals involved in our dispensing of medical supplies. This request must be given to us in written form.
- **I**nspection and Copies. You have the right to request a copy of the identifiable health information that we may utilize for your care. This request must be provided in writing.
- **A**mendment. You may request that we amend your information if you think that we have incorrect information in our records. This request must be provided in writing.
- **A**ccounting of Disclosures. All of our patients have the right to request a list of any disclosures our organization makes of your personal information (such as to your medical doctor or to our technician).
- **Y**ou have a right to a copy of this notice.
- **Y**ou have the right to file a complaint if you believe your privacy rights have been violated.

Jennifer Nichols is the compliance officer for BAYWEST MEDICAL , LLC and can be reached at **727-372-0091**.

Initials_____ I have received a copy of BayWest's Privacy Notice.



BAYWEST MEDICAL

, D.C.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

_____ LAST 4 SS #: _____

I request and authorize ALL MEDICAL PROVIDERS to release healthcare information of the patient named above to:

Name: BAYWEST MEDICAL, LLC

Address: 5633 STATE ROAD 54 _____

City: NEW PORT RICHEY State: FL Zip Code: 34652

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

_____

All healthcare information

Other: _____

Patient Signature:_____ Date Signed:_____

BAYWEST MEDICAL,LLC
5633 State Rd 54
New Port Richey, FL 34652
727-372-0091
727-372-0192

Disclosure and Informed Consent
Treatment Protocols

In this office, we utilize trained staff personnel to assist the doctor with portions of the physical examination, X-ray taking, Cold Laser Protocols, Stretching and Exercising instructions, etc.

Stroke: Stroke is the most serious problem that has been associated with Chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. In extremely rare instances Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because of vertebral artery is found inside the neck vertebrae. Certain types of high velocity neck adjustments may potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Spine, Vol. 33 No., February 2008)

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently treated by Chiropractors and Chiropractic adjustments, traction, etc. This includes both neck and back. Yet, occasionally Chiropractic treatments (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely Chiropractic adjustments may also cause worsening of a pre-existing disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statics to quantify their probability.

Soft Tissue Injury: Sort tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a Chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments of resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a Chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for Chiropractic adjustments, traction, massage therapy, passive stretching, exercises, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about any soreness you experience.

Other Problems: There may be other problems or complications that might arise from Chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health delivery, and therefore, as with any health care delivery system we cannot promise a cure for ANY symptom, disease, or condition because of treatment at this office. We will always give you our best care, and if results are not acceptable, we will refer you to another provider we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please initial and date below.

Patient Initials: _____ **Date:** _____

BAYWEST MEDICAL, LLC
5633 State Rd 54
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Patient: You have the right as a patient to be informed about your condition and the recommended modalities and therapies to be used, so that you may make an informed decision whether to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply to make you better informed so you may give or withhold your consent to the recommended modalities and procedures.

I hereby request and consent to the performance of Chiropractic adjustments, Diagnostic X-rays, Cold Laser Protocols, EMS, Hydro Therapy, passive stretching, active stretching, and exercises, on me even if I have had previous auto-immune disorder(s) and /or cancer(s) (or the patient named below for whom I am legally responsible by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treated me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I can discuss with the Doctor of Chiropractic at BAYWEST MEDICAL.LLC , my diagnosis, the nature and purpose of Chiropractic adjustments and other procedures and alternatives.

I understand and have been informed that, in the practice of Chiropractic there are some risk to exam and treatment including, but not limited to: fracture, disc injuries, strokes, dislocations, sprains and increases symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I rely on the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based on the facts then known, is in my interest. I further acknowledge that no guarantees or assurances have been made concerning the results intended from the treatment.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print Patient Name

_____
Patient Signature

_____
Date

To be completed by the patient's representative. If necessary, e.g., if the patient is a minor or physically or legally incapacitated.

_____
Print Name of Patient

_____
Print Name of Patient Representative

_____
Patient Representative Signature

As: _____
Relationship or Authority Patients Representative

_____
Date

Completed by the Doctor or Staff

_____ _____
Witness to Patient's Signature Date

_____ _____
Translated By Date