Todayôs Date: _____
^ **(Office Use only)**

Patient ID#_____
^ **(Office Use only)**

Please read every question carefully and try answering ***every*** *question, we pride ourselves in being extra thorough to provide you with the best care possible.*

Oasis Chiropractic Center Patient Application Form

Please note that ❑ **n/a** refers to **"Not Applicable"** on these forms

Last Name: _____ First Name: _____

Preferred /Nick Name: ❑ n/a _____
Prefix / Title: (check one) Mr.❑ Mrs.❑ Ms. ❑ Miss ❑ Dr.❑ Other:_____

Do you currently have any cold, flu or Covid like symptoms? No ❑ Yes ❑

Have you or anyone in your household tested positive for Covid-19 in the past 15 Days? No ❑ Yes ❑ ❑Self Other: _____

What was the approximate date of your last Covid-19 Test? ❑ n/a _____/ _____/ _____ Positive ❑ Negative ❑

If yes, approx. date of 1st Positive Exam _____/ _____/ _____, approx. date of last negative Exam _____/ _____/ _____

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____ Are you active Military or a Veteran? Yes ❑ No ❑

Date of Birth: _____/ _____/ _____ Age: _____
>>>Single❑ Married❑ Widowed❑ Under 18 (Minor)❑ Separated❑ Divorced❑ Domestic Partnership❑

Address: _____ Apt: _____ City: _____ State_____ Zip: _____
I am visiting from out of town❑ I live abroad❑ I live in Miami, only Part-Time /Sometimes/ Temporarily❑

Cell Phone: _____ Work Phone: ❑ n/a _____ Assistantôs Phone: ❑ n/a _____

Letôs keep in touch: Please note that your information is *kept* strictly *confidential* and is ***not*** shared with any outside parties.
If Dr. Starkman needs to send you any information like (homecare, nutritional survey, stretches etc.) He'll send it to the email address you have provided ^^^^above, if you choose to receive email appointment reminders it will be sent to the email you have provided above. Please make sure it's legible.

E-Mail address_____@_____
(Please print legibly)

Employment Status: Employed❑ Self Employed❑ Unemployed❑ F/T Student❑ P/T Student❑ Stay at home Mom❑ Homemaker❑ Other❑

Your favorite Hobbies or Interest (**helps us identify physical stresses**): _____

Work Stress Level (*circle the number that best* describes you) > 6 always 5 almost always 4 most of the time 3 sometimes 2 rarely 1 never

Your Occupation ❑ n/a _____Employer_____ Self Employed ❑

Home Stress Level (*circle the number that best* describes you) > 6 always 5 almost always 4 most of the time 3 sometimes 2 rarely 1 never

Number of Children ❑ n/a (___) Name:_____ Age: ___Name: _____ Age: ___Name: _____ Age:____

How did you find out about Oasis: ❑ Internet /Google ❑ FaceBook ❑ Twitter ❑ Can't remember
❑ Iôm a Prior Patient ❑ Health Fair/Educational Work Shop ❑ Office Staff
Other ❑ **If you were referred by someone, *please tell us* their name *so we can thank them*!**
❑ Co-Worker/ Employer / Name: _____ ❑ Family Member/ Name_____
❑ Friend(s)/ Name(s): _____ ❑ Spouse/GF/BF/Partner /Name _____

Are you a Prior Patient at Oasis? No ❑ Yes ❑ Date of last visit ? _____/ _____/ _____ Why did you discontinue care? TIME ❑ MONEY❑ BOTH❑ OTHER❑

Have you been to a Chiropractor before? Yes ❑ No ❑ Doctorôs Name_____ Office Name: _____State____ When?_____

Have you ever had an automobile accident? No ❑ Yes ❑ When? _____ / _____ ❑ Donôt Remember
Month Year

Have you had a prior diagnostic imaging study or examination (MRI or X-ray) etc. in the last **2 years**? If yes, please list: ❑ None

Body Part:	Month-Year
MRI _____	_____ / _____ ❑ Donôt Remember
X-Ray _____	_____ / _____ ❑ Donôt Remember
Ultrasound _____	_____ / _____ ❑ Donôt Remember

OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131

❑Here for a **Wellness Visit / Self-Care**, no complaints just want to feel my best and de-stress.

What are your present Complaints or Health Concerns? LIST

Complaint / Concern 1:	**Complaint** / Concern 3:
Complaint / Concern 2:	**Complaint** / Concern 4:

How many H**ours** do you sleep each night and do you have *difficulty* falling asleep? **Hours:** _____ *difficulty* > Yes❑ No❑

Pain or problem started on _____/_____/_____ aprox. Pains are (please circle one): Sharp Dull Constant Intermittent
❑I donôt know^^^^
I think my condition was caused by: _____ My condition is worse when I: _____
❑I donôt know^^^^
Is condition worse during certain times of the day? Yes ❑ No ❑ When? _____

Have you been treated by another Physician for this condition? Yes ❑ No ❑ Whom: _____ When?_____

❑ I'm trying to get pregnant ❑n/a ❑ I'm _____ weeks pregnant ❑n/a

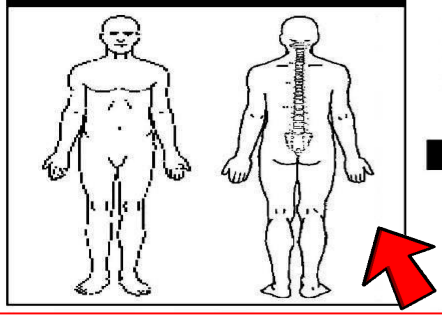
❑ My Baby is Breech ❑n/a ❑ My baby is Late ❑n/a ❑ Iôm here for preventive care **DUE DATE:** _____

Name OB Doctor: _____ ❑n/a Birthing Center: _____ ❑n/a Name of Mid-Wife:_____ ❑n/a

❑Do you smoke? YES❑ NO❑ ❑Do you exercise? YES❑ NO❑ ❑Do you participate in sports? YES❑ NO❑

MAJOR COMPLAINT INFORMATION CONTINUED...

Please mark your areas of pain on the figures below:



Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine
☐ Other _____

Have you received any treatment for this condition? ☐ Yes ☐ No
If Yes, please explain_____

Have you been in an auto accident: ☐ Past year ☐ Past 5 years
☐ Over 5 years ☐ Never

HABITS

❑ Smoking	Packs/Day: _____
❑ Alcohol	Drinks/Day: _____
❑ Coffee	Cups/Day: _____
❑ Soft Drinks	Drinks/Day: _____
❑ Water	Glasses/Day: _____

EXERCISE

❑ None
❑ 1-2 days/week
❑ 3-4 days/week
❑ 5+ days/week
Type :
_____

Please List ***all*** Surgeries (*elective & non-elective) you've* had with dates from most current: ❑n/a: (____/_____/_____) _____

(____/_____/_____) _____ Date: (____/_____/_____) _____

(____/_____/_____) _____ Date: (____/_____/_____) _____

Have you had any of the following in the last year: Please check all that apply: New Health Diagnosis❑ Sleep Problems❑
Surgery/ Elective or other❑ Had a Baby❑ Digestive Issues❑ Moved❑ Death in the Family❑ Caring for an Elderly Parent❑ Got Divorced❑
Family Break-Up or Separation❑ Major personal injury or illness❑ Retirement❑ Infertility❑ Loss of a Pet❑ Experienced Mental Health Issues❑
Unemployment❑ Changed Jobs❑ Got Married❑
Significant Stressful Life Event other ❑ Explain_____ ❑NONE

CHECK ALL THAT APPLY:

Life Style Activities	Never Tried	Tried Before	Use Currently	Interested in:?
Acupuncture	❑	❑	❑	Yes ❑ No ❑
Meditation	❑	❑	❑	Yes ❑ No ❑
Yearly Detox & Cleansing	❑	❑	❑	Yes ❑ No ❑

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Please read all the sections on this form, your health history is very important, check if you've had **previously**. **These are NOT all Diseases.**
CHOOSE **PREVIOUSLY** OR **PRESENTLY**:

CHECK THE FOLLOWING CONDITIONS AS THEY APPLY TO YOU

Previously	Presently	GENERAL SYMPTOMS/ CONDITIONS
☐	☐	Migraines
☐	☐	Headache
☐	☐	Bronchitis
☐	☐	Chills (Constant)
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Trouble Sleeping
☐	☐	Loss of Weight
☐	☐	Nervousness
☐	☐	Night Sweats
☐	☐	Numbness or Pain in arms/legs/hands
☐	☐	Wheezing
☐	☐	Polio
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Chicken Pox
☐	☐	Rheumatic Fever
☐	☐	Pleurisy
☐	☐	Arthritis
☐	☐	Mumps
☐	☐	Cancer
☐	☐	Tuberculosis
☐	☐	Venereal Disease
☐	☐	HIV Positive
☐	☐	Diabetes
☐	☐	Measles
☐	☐	Serious Injury
☐	☐	Allergy (to what)

_____

Previously	Presently	GASTRO-INTESTINAL
☐	☐	Belching or Gas
☐	☐	Acid Reflux
☐	☐	Heart Burn
☐	☐	Colon Trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Gall Bladder Trouble
☐	☐	Hemorrhoids (piles)
☐	☐	Jaundice
☐	☐	Liver Trouble
☐	☐	Nausea
☐	☐	Stomach Pain
☐	☐	Vomiting
☐	☐	Vomiting Blood
☐	☐	Bloody Stool
☐	☐	Irritable Bowel
☐	☐	Ulcers

CARDIO-VASCULAR

☐	☐	High Blood Pressure
☐	☐	Strokes
☐	☐	Low Blood Pressure
☐	☐	Chest Pain
☐	☐	Heart Trouble
☐	☐	Poor Circulation
☐	☐	Rapid Heart
☐	☐	Slow Heart
☐	☐	Swollen Ankles
☐	☐	Varicose Veins
☐	☐	Pacemaker
☐	☐	_____other
☐	☐	_____other

Previously	Presently	EYE/EAR/ NOSE/THROAT
☐	☐	Sinusitis
☐	☐	Asthma
☐	☐	Deafness
☐	☐	Earache
☐	☐	Ear Discharge
☐	☐	Ear Noises
☐	☐	Thyroid Problems
☐	☐	Frequent Colds
☐	☐	Hay Fever
☐	☐	Nasal Obstruction
☐	☐	Nose Bleeds
☐	☐	Pain in Eyes
☐	☐	Poor Vision
☐	☐	Blurred Vision
☐	☐	Sore Throats
☐	☐	Tonsillitis

MUSCLES & JOINTS

☐	☐	Backache
☐	☐	Pain Between Shoulders
☐	☐	Stiff Neck
☐	☐	Foot Trouble
☐	☐	Hernia
☐	☐	Painful Tail Bone
☐	☐	Spinal Curvature
☐	☐	Swollen Joints
☐	☐	Tremors
☐	☐	Twitching
☐	☐	Spinal Disc Disease
☐	☐	Dislocated Joints

Previously	Presently	RESPIRATORY
☐	☐	Chronic Cough
☐	☐	Difficulty Breathing
☐	☐	Spitting Blood
☐	☐	Spitting Phlegm

GENITO-URINARY

☐	☐	Bed Wetting
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Inability to Control Urine
☐	☐	Kidney Infections
☐	☐	Kidney Stones
☐	☐	Painful Urination
☐	☐	Prostate Trouble

NEUROLOGICAL

☐	☐	Anxiety
☐	☐	Mood Swings
☐	☐	Phobias
☐	☐	Mental Disorders
☐	☐	Multiple Sclerosis
☐	☐	Epilepsy
☐	☐	Memory Loss or Impairment
☐	☐	Depression

FOR FEMALES ONLY

☐	☐	Irregular Cycle
☐	☐	Cramps
☐	☐	Hot Flashes
☐	☐	Painful Periods

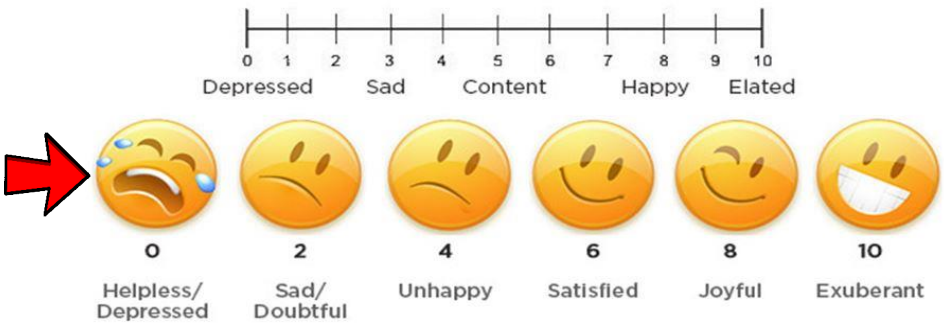
☐ Yes ☐ No **Pregnant at this time?**

_____Last Menstrual Cycle

YES, WE REALLY DO WANT YOU TO FILL OUT THE FOLLOWING SECTION, pick a number and a face:

Rate Your Happiness: R U Happy?

On a scale of 1-10 rate your level of general happiness.
With 1 being not at all happy and 10 being as happy as can be. Not just today but in general.



Check all that apply:

over-worked❑ Short of time❑ The conditions in my life are excellent❑ over-stressed❑ I am satisfied with life❑
under-valued❑ living life out of balance❑ plagued by busyness❑ In most ways my life is close to ideal❑
under-productive❑ If I could live my life forever I would change almost nothing❑ I'm full of energy❑ I feel helpless❑ **NONE APPLY** ❑

ADDITIONAL INFORMATION

List all medications you are taking now, including over the counter medication: _____

_____

Do you have, or have you ever had, any diseases or medical problems not listed? ☐ Yes ☐ No

If so, please list: _____

_____

Any additional information you would like the doctor to know about before beginning care ?

_____

Oasis Chiropractic Center Payment Information

Responsible Party:

Name of person responsible for this account: _____ ❑ Self

Relationship to patient: _____ ❑ Self

Are you currently being represented by an attorney for any reason? ❑ No ❑ Yes, if yes whom & why? _____

Name: _____ Address: _____ Telephone No. _____

To the best of my knowledge, the information I have provided in page 1 , 2 , 3 & 4 of the Patient Application Form is complete and correct. **I understand that it is my responsibility to inform my doctor and the office staff if I or my minor/child ever has a change in health, are injured in any type of accident, retain legal representation or if there is ever a change in my contact information such as address or telephone number etc.** It is also my responsibility to inform the doctor of any medications prescribed in the course of my treatment and to advise the staff if I am scheduled for any type of in/outpatient procedure.

- Oasis Chiropractic Center is a **NON-PARTICIPATING PROVIDER/ *out-of-network provider*** with insurance companies. We are a cash (we accept credit cards) based practice and do not accept insurance as of January **2014. Oasis Chiropractic Center will however provide you with a Super Bill/ Receipt of services rendered and paid so that you may submit the claims yourself for direct reimbursement.** Please note that Oasis Chiropractic Center can no longer verify patientôs insurance benefits, you will need to contact your insurance company directly to obtain your reimbursement information.

- **Our office does not guarantee that your insurance company will pay for treatment** you receive from our practice. We perform routine insurance billing procedures for only Medicare and Personal Injury patients.

- **Our office will not enter into a dispute with your insurance company** over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

- **USUAL AND CUSTOMARY RATES:**

Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance companyôs arbitrary determination of usual and customary rates.

- _____ **Initials**

LATE ARRIVAL POLICY: A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while travelling to the office for their appointment. If a patient arrives more than 15 minutes late for their appointment, the patient will be given the option of either being seen that day, but may have to wait till the schedule permits, or rescheduled for a later date. This process will ensure patients that do arrive on time are seen in a timely manner. As a courtesy we ask that you text or call the office if you know you will be running late, this will also help us minimize your wait time if we can plan ahead. Patients, who arrive more than 30 Minutes late to their visit will be counted as a **NO SHOW/MISSED APPOINTMENT**, please see the Oasis No Show/Missed appointment office policy to follow. Please note that appointments are canceled after 30 Minutes, you must call and speak to a member of our team to see if you can still be seen.

I understand that payment is due at the time of service for all CASH patients unless otherwise arranged with Oasis Chiropractic Center.
My signature below attests that I have read and understood the Oasis Chiropractic Center Payment Information.

_____

Please print name of **Patient**, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____

Signature of **Patient**, Parent, Guardian or Personal Representative Date

OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131
PHONE: 305-374-5866

INFORMED CONSENT TO SERVICES

I hereby consent to the performance of comprehensive examinations, chiropractic adjustments, and other chiropractic procedures, various modes of physiotherapy, acupuncture, massage, and nutritional advice by Dr. Myles Starkman and staff, which now or in the future treat me in this office. I have had an opportunity to discuss with Dr. Myles Starkman and Oasis Chiropractic Center staff the nature and purpose of the recommended treatment/ care. I understand that results are **not** guaranteed.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I am informed that clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or healthcare if he is aware that such care may be contra-indicated.

Some treatments may include electrical stimulation which has the following contraindications:

Pacemaker
Pregnancy
Epilepsy/Seizures (no treatment above the neck)
Cancer

Electrical stimulation or ñe-stim,ò involves the use of electric devices such as TENS (Transcutaneous Electrical Nerve Stimulation), or MENS (Microcurrent Electrical Nerve Stimulation).

I understand I must inform my doctor if I have any of the above contra-indications.

I do not expect the doctor to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment for at this facility.

_____
Please print name of **Patient**, Parent, Guardian or Personal Representative Relationship to Patient

_____
Signature of **Patient**, Parent, Guardian or Personal Representative

_____
Date

OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131
PHONE: 305-374-5866

Informed Consent to Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, laser, electro acupuncture, and other techniques within the scope of practice of the doctor.

These procedures may be performed by the doctor or another duly authorized person in the clinic.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that the results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable.

I further understand and am informed that, as with all health care, the practice of acupuncture possesses slight risks from treatment, including, but not limited to, temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock.

I do not expect the doctor to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures(s). I intent this consent form to cover the entire course of my present condition and for any future condition(s) for which I seek treatment.

Informed Consent to Gua Sha & Cupping

Massage Cupping uses negative pressure created within a specialized glass or rubber cup that is applied to the affected body part. The pressure can be deep to provide relief from tension, pain and injuries. Gentler pressure increases lymph flow, circulation and relaxation, and is excellent for facial treatments. Gua Sha is similar to cupping in results, but a round-edged tool is used in strokes to pressure specific areas of muscle pain.

There is a possibility of discoloration that can occur from the release and clearing of stagnation and toxins from the body. The reaction is not bruising, but the cellular debris, pathogenic factors and toxins being drawn to the subcutaneous layers for dissipation by the circulatory system.

The discoloration, or *sha*, will dissipate in as soon as a few hours or up to 1 week, and in relation to after-care activities. It is important to drink plenty of water to stay hydrated, and avoid vigorous exercise for 24 hours after treatment.

Avoid exposure to extreme temperatures, including cold, wet and/or windy weather conditions, hot showers, baths, saunas, hot tubs, for 24 hours after treatment.

- ○ I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.
- ○ If I choose to experience cupping therapy and/or Gua Sha during treatments, I understand the potential side-effects and the after-care recommendations.
- ○ I also agree that I have read, understand and will follow all the information stated above and will not hold the practitioner responsible.

_____

Signature Date

OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131
PHONE: 305-374-5866

OASIS NO SHOW / MISSED APPOINTMENT POLICY

We, at Oasis Chiropractic Center, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least 24-hour notice).
You can cancel appointments by texting 305-374-5866. To ensure that each patient is given the proper amount of time prearranged for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. It is the responsibility of the patient to arrive for their appointment on time. Patients arriving more than 15 minutes late without calling the office may have to re-schedule. Appointments are canceled after 30 Minute tardy.

PLEASE REVIEW THE FOLLOWING POLICY

1. Please cancel your appointment with at least 24 hoursônotice so your appointment time can be offered to other patients.
2. If less than a 24-hour cancellation is given, this will be documented as a ñNo-Showò appointment.
3. If you do not show up to your scheduled appointment, this will be documented as a ñNo-Showòappointment.
4. After the first ñNo-Show/Missedòappointment, you will receive a phone call or text warning that you have broken our ñNo-Showòpolicy. We will assist you in rescheduling this appointment if needed.
5. If you have two (2) or more ñNo-Show/Missedòappointments, you will be charged a $35.00 no show fee for each appointment missed.
6. If you have three (4) or more ñNo-Show/Missedòappointments, you will be charged a $70.00 no show fee for each appointment missed and you will have to attend a meeting with the doctor to continue care with Oasis Chiropractic Center.

I have read and understand Oasis Chiropractic Center No-Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Oasis Chiropractic Center appropriately if I have difficulty keeping my scheduled appointment.

Patient Name: _____ Date: _____

Patient Signature: _____