San Jose Chiropractic
12276 San Jose Boulevard - Suite 512
Jacksonville, FL 32223
904-683-4476

Confidential Patient Information

Name: _____ Hm Phone: _____ Wk/Cell Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Marital Status (circle one) M S D W Age _____

Social Security Number _____-____-_____ E-mail Address _____

Occupation: _____ Employer: _____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

Who may we thank for referring to our office: _____

Have you ever had Chiropractic care before? Yes ☐ No ☐ Date: _____

Is this injury/illness related to: Automobile Accident ☐ Pregnancy ☐

Date/Time: _____ Location: _____

Your Auto Insurance Co: _____ Phone: _____

Third Party Auto Insurance Co: _____ Phone: _____

All charges are due when services are rendered…

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

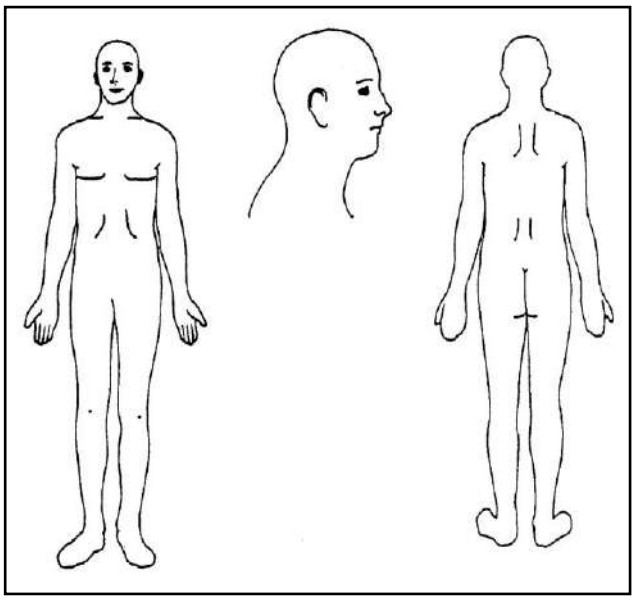
I authorize San Jose Chiropractic to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

Thank You For Allowing Us To Serve You!

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Medications:_____
_____
Surgeries:_____
_____
Auto Accident:_____
Falls/ Injuries_____

Hobbies_____

_____

Check any of the following you have had in the six months:

( ) Headaches / Migraines
( ) Frequent Nausea/ Vomiting
( ) Vision Problems
( ) Ears (Pressure/ Infection/ Ringing)
( ) Dizziness /Vertigo
( ) Heart (Palpitation / Disease)
( ) Lung Problems / Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate/ Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Sinus Congestion/ Allergies
( ) Numbness /Tingling/ Weakness
( ) Throat (Swallowing/Sore)
( ) Abdominal Cramps
( ) Constipation/ Diarrhea
( ) Acid Reflux
( ) Poor / Excessive Appetite
( ) Excessive Thirst
( ) Painful / Excessive Urine
( ) Discolored Urine
( ) Diabetes
( ) Cancer

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

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

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1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

SAN JOSE CHIROPRACTIC

Thuraia Owais, D.C.
12276 San Jose Blvd, STE 512
Jacksonville, FL 32223
(904)683-4476

Informed Consent to Chiropractic Care

Terms of acceptance for care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may take the decision whether to undergo chiropractic care after being advised of the known benefits, risks, and alternative.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

Health is the state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity

Vertebral subluxation is the disturbance to the nervous system that occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are correct and/or reduces by an adjustment

Adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instrument. In addition, ancillary procedures such as extremity adjustment, physiotherapy and or rehabilitation procedures maybe included.

If during the course of care we encounter non-chiropractic or usual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternative 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

SAN JOSE CHIROPRACTIC

Patient Acknowledgement and/or Receipt of

Notice of Privacy Practices Pursuant to HIPAA
And Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does herby acknowledge that her or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does herby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant To HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____day of _____, 20_____

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By _____
Signature of Parent/Guardian (circle one)

12276 San Jose Blvd, Suite 512 * Jacksonville, FL 32223
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Insurance Disclaimer

If you have insurance, as a courtesy, we will do a verification of benefits to see what coverage and reimbursement you have. You are responsible for the billing. We will provide a superbill and the claim forms needed. Medicare patients will be filed by our office.

It is your responsibility to provide all correct and necessary insurance eligibility, identification, authorization and to notify our office of any information changes when they occur. With most insurance companies we have a short window to file your claim. If we pass this window of opportunity your policy may state that the insurance has no responsibility to pay on your claim. Unfortunately, even a preauthorization of services does not guarantee payment from your insurance carrier. Failure to provide all required information may necessitate patient payment in full for all charges. We have no control over contractual downgrades of services by your insurance company and assume no monetary liability based upon any downgrade of benefits. The insurance company will not disclose this information ahead of time. Because of the quality of our work, we cannot allow insurance companies to dictate our services or the materials that we may use.

Please be aware that you as the guarantor are responsible for payment on your account in a prompt and timely manner, usually 30-45 days from date the service was rendered, whether insurance has paid or not.

_____ _____

Signature Date