Oceanside Wellness Center
Dr. Lee Weiner, D.C.
3218 Long Beach Road. Oceanside, NY 11572
(516) 255-0272

TELL US ABOUT YOU **(PLEASE PRINT CLEARLY)**

NAME:		SOCIAL SECURITY #:		DATE:
DATE OF BIRTH:	AGE:	SEX: M F	MARITAL STATUS: M S D W	# OF CHILDREN:
ADDRESS:				
CITY:		STATE:		ZIP:
HOME PHONE #:		CELL PHONE #:		
E-MAIL ADDRESS:		OCCUPATION:		
COMPANY NAME:		LENGTH OF EMPLOYMENT:		
TYPE OF WORK:	OFFICE/CLERICAL	LIGHT LABOR	MODERATE LABOR	HEAVY LABOR
SPOUSES NAME:				
IN CASE OF EMERGENCY CONTACT NAME:		HOME PHONE #:		

TELL US ABOUT YOUR PAST HEALTH

Y	N	← Frequent Neck Pain	Y	N	← Alcohol / Drug	Y	N	← Stroke
Y	N	← Lower Back Pain	Y	N	← Hepatitis	Y	N	← Heart Surgery / Pacemaker
Y	N	← Frequent Headaches	Y	N	← HIV / Aids	Y	N	← Heart Murmur
Y	N	← Fainting / Seizures /	Y	N	← Shingles	Y	N	← Congenital Heart Defect
Y	N	← Arm / Leg Pain	Y	N	← Cancer	Y	N	← Mitral Valve Prolapse
Y	N	← Arthritis	Y	N	← Chemotherapy	Y	N	← Artificial Valves
Y	N	← Artificial Limbs /	Y	N	← Anemia	Y	N	← Rheumatic Fever
Y	N	← Asthma / Emphysema	Y	N	← Difficulty Breathing	Y	N	← Diabetes / Tuberculosis
Y	N	← Ulcers / Colitis	Y	N	← Psychiatric Problems	Y	N	← High / Low Blood Pressure
Y	N	← Kidney Problems	Y	N	← Heart Attack	Y	N	← Fractures
Y	N	← Workers Comp	Y	N	← Personal Injuries	Y	N	← Sports or Other Injuries to Head,
Y	N	← Hospitalized	Y	N	← Chiropractic Care	Y	N	← Surgery

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:
PLEASE LIST ANY VITAMINS YOU ARE CURRENTLY TAKING:
PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS YOU HAVE EVER HAD:

PRIMARY CARE PHYSICIAN:	PHONE #:
DATE OF LAST DOCTOR VISIT:	
LIST ANY THING YOU MAY BE ALLERGIC TO:	
LIST PAST SERIOUS ACCIDENTS:	

FAMILY HEALTH HISTORY:	DIABETES	CANCER	HEART DISEASE / STROKE	OTHER:
DO YOU SMOKE? Y N	HOW LONG?		PACKS PER DAY:	
ALCOHOL CONSUMPTION?	NEVER	SOCIAL	LIGHT	MODERATE HEAVY

FOR WOMEN ONLY

DO YOU TAKE BIRTH CONTROL?	Y	N	IF YES, FOR HOW LONG?				
ARE YOU NURSING?	Y	N	ARE YOU PREGNANT	Y	N	DELIVERY DATE?	

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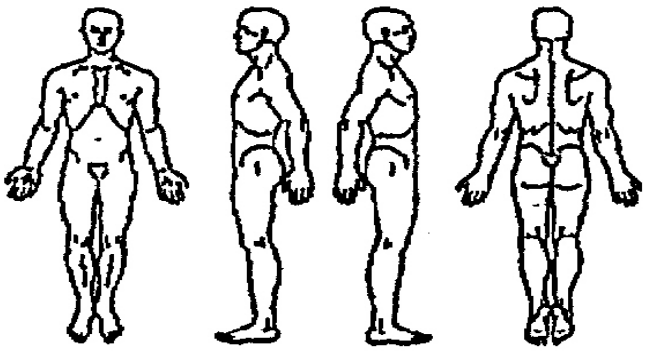
Name _____REASON FOR THIS VISIT Date_____

THE REASON FOR THIS VISIT IS A RESULT OF (PLEASE CIRCLE):	AUTO ACCIDENT	WORK INJURY	TRAUMA	SPORTS
	GRADUAL ONSET	CHRONIC	OTHER	
DATE OF INJURY / WHEN DID THE CONDITION BEGIN?				
IS THE CONDITION GETTING WORSE?	Y	N		
EXPLAIN WHAT HAPPENED:				
IS THIS CONDITION INTERFERING WITH YOUR (PLEASE CIRCLE):	WORK	SLEEP	DAILY ROUTINE	OTHER:
IF SO, PLEASE EXPLAIN:				

Please darken the body part(s) in which you are currently experiencing symptoms:



CHIEF COMPLAINTS

	Where does it hurt?	ONSET (When did the pain start?)	PROVOCATIVE (What makes it worse?)	PALLIATIVE (What makes it better?)	QUALITY (Achy, stiff, sharp, burning, etc.)	RADIATION (Does the pain go down your arm / leg?)	SEVERITY (1 – 10)	TEMPORAL (When does it hurt? Constant, On and off)
1.								
2.								
3.								
4.								
5.								

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AUTHORIZATIONS: Name: _____ Date:_____

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment of this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. Unpaid balance of more than 90 days will be turned over to a collections agency.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT**:**	
INSURANCE COMPANY:	PHONE #:
GROUP #:	ID #:

Signature_____ **Date** _____

Guardian Signature_____ **Date** _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache.

Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/ or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____Date _____

Parent or Guardian: _____ Signature: _____Date _____

Witness Name: _____ Signature: _____Date _____

Health Information Consent for Purpose of: Treatment, Payment, and Healthcare Operations

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Dr. Lee Weiner for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by Dr. Lee Weiner.

I understand that Dr. Lee Weiner may refuse to diagnose or treat me, if I do not consent to the
use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent).

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Dr. Lee Weiner is not required to agree to the restrictions that I may request. However, if Dr. Lee Weiner agrees to a restriction that I request, the restriction is binding on Dr. Lee Weiner.

I understand I have a right to review Dr. Lee Weiner’s Notice of Privacy Practices prior to signing this document. Dr. Lee Weiner’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Dr. Lee Weiner. The Notice of Privacy Practices for Dr. Lee Weiner is also provided to me on request at the main administrative desk of the practice. Dr. Lee Weiner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Dr. Lee Weiner and requesting a revised copy or asking for one on my next appointment.

I have the right to revoke this consent, in writing; at any time except to the extent of Dr. Lee Weiner has taken action in reliance on this consent.

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative