2237 North Commerce Parkway, Ste 2
Weston, FL 33326
Phone 954-888-6650 ● Fax 954-888-6645
www.westonmedicalhealth.com

The Next Generation in Healthcare

CONFIDENTIAL PATIENT INFORMATION

Full Legal Name:_____/_____/_____
(Last Name) (First Name) (Middle Initial)

Preferred Name:_____Age:_____Date of Birth:_____S.S.#: _____

Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (zip code)

Telephone # (____)_____ (____)_____ (____)_____
(home) (work) (cell phone or other)

Email:_____Gender:_____Primary Language Spoken:_____

Are you (check one): Single_____Married_____Other_____Partner's Name: _____

Race:_____ Ethnicity:_____Emergency Contact:_____

Occupation:_____(circle) Full time/ Part time /Student/ Retired

Employer / School: _____

Address:_____/ _____/_____/_____
(Street / PO Box) (City) (State) (Zip code)

Name of Primary Care Physician:_____Contact Number:_____

How were you referred to our office? _____
May we send you information regarding your care via email? Yes_____No_____

May we send you educational/promotional materials such as newsletters via e-mail? Yes_____No_____

INSURANCE INFORMATION

Insurance Information – Please provide Insurance Card and State Driver's License at Front Desk
□ **Group Insurance:** Insurance Co:_____Member ID: _____
Insured Full Legal Name:_____Date of Birth:___/___/_____

Insured's Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)

□ **MVA:** Date of MVA:_____State MVA occurred:_____Claim number: _____
Insurance Co:_____Claim submitted □ Y □ N Adjuster:_____Phone: (___) _____

Attorney's Name:_____Phone: (___)_____PIP Coverage: _____

Do you have any secondary or additional Insurance plans? □ Yes □ No Name: _____

MEDICARE INSURANCE PATIENTS ONLY

Do you have a Private Medicare HMO Policy/Plan? ☐ Yes ☐ No
Are you currently receiving HOME HEALTH CARE? ☐ Yes ☐ No

By signing below, I certify that the above information is correct and true to the best of my knowledge.

Signature of Patient/Responsible Party_____Today's Date_____

ASSIGNMENT OF BENEFITS

I, the above/below-named patient, by signing below, hereby irrevocably assign to WESTON MEDICAL HEALTH CENTER, any and all of my rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined by Florida law, for any services and charges provided by WESTON MEDICAL HEALTH CENTER. It is the intent of the undersigned that this assignment is irrevocable and shall apply to any and all causes of action, lawsuits, claims, counter-claims, and demands.

I understand that in the event it becomes necessary to collect monies owed through an attorney, I will be responsible for all costs including, but not limited to, attorney's fees and court costs. I also understand that this assignment of benefits gives WESTON MEDICAL HEALTH CENTER the right to file a lawsuit against my insurance company, or the applicable insurance company.

By signing below, I certify I have read this assignment of benefits and I understand all of the terms and conditions. I acknowledge that all of my questions concerning this assignment of benefits have been fully explained to me by Weston Medical Health Center.

_____Initials

STATEMENT OF CONFIDENTIALITY

I authorize payment of insurance benefits directly to the doctor or doctor's office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claims.

_____Initials

PRIVACY PRACTICE NOTIFICATION

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

- A full copy of the patient's Bill of Rights is available upon request

_____Initials

ADVANCED BENEFICIARY NOTICE (ABN) MEDICARE Only

You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit to our office.

What you need to know:

- Read this notice, so you can make an informed decision about your care.
- Ask Questions.

Chiropractic Services: Only 98941. 98942, 98943 are covered. All other services and/or supplies provided by Chiropractor will be at an additional fee.

__Yes, I want to receive these services.

__No I have decided not to receive these services.

__Other should I decide to request these services in the future, I understand I will be charged and am responsible for full payment.

By Signing this notice you agree to take financial responsibility for the cost of the supplies and/or services listed above should your insurance company deny coverage for the listed items.

PATIENT RESPONSIBILTY

All co-pays are due at time of service.

Insurance companies provide providers **non guaranteed** information upon verification of benefits and may reimburse differently upon claim payment. You are responsible for deductibles, adjustments or unpaid balances made by your insurance.

If your insurance company/plan overrides the assignment of benefits and makes claim payments directly to you, you are responsible to pay Weston Medical Health Center upon receipt. A payment arrangement for these services after an insurer has paid you is not acceptable. A copy of the Explanation of Benefits must accompany the check(s) so we may record your account properly.

I authorize Weston Medical Health Center to retain my credit card on file for recurring billing, co pays, deductibles and unpaid balances.

- A full copy of the financial policy is available upon request

_____Initials

By signing below, I certify that the information I furnish is true and correct. I know that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature of Patient/Responsible Party_____Today's Date_____

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Please Answer All Questions to the best of your ability

CURRENT HEALTH CONDITION

Patient Name: _____ **Date:** _____
Fecha

What is your chief Complaint or Reason for your Visit today? _____

Date of onset/injury: _____

Have you received treatment for injury? ☐ Yes ☐ No

Is your pain the result of an auto accident, slip or fall? ☐ Yes ☐ No

If Yes, please indicate what type: ☐ **Auto** ☐ **Work** ☐ **Personal Injury** ☐ **Home**

Have you been fitted for a custom BACK brace within the last 3 years? ☐ Yes ☐ No

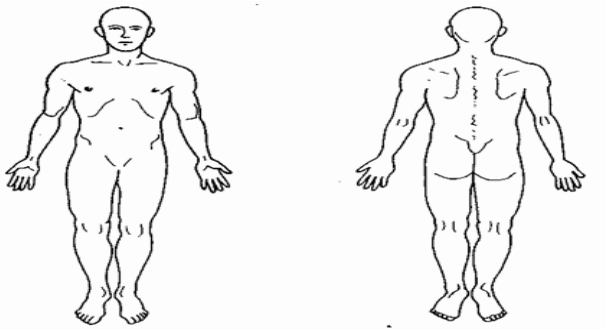
Have you been fitted for a custom KNEE brace within the last 5 years? ☐ Yes ☐ No

What kind of pain?

Where is the pain?			**What type of pain?**				
Arms:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Legs:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Knees:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Hips:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Shoulders:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Elbows:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Wrists:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Feet:	Left	Right	☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Head:			☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Neck:			☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing
Back:			☐Ache/Dull	☐Burning	☐Stabbing	☐Pins & Needles	☐Sharp Throbbing

When your pain is at its worst, rate the severity on a scale of 1 – 10

Indicate where you have pain or other symptoms



Increase Pain: ☐ Sit ☐ Stand ☐Walk ☐Climb ☐ Bend ☐ Squat
☐ Up Stairs ☐Down Stairs ☐ Movement ☐Lay Down ☐ Touch

Decrease pain: ☐ Sit ☐ Stand ☐ Walk ☐ Climb ☐ Bend ☐ Squat
☐ Up Stairs ☐ Down Stairs ☐ Movement ☐ Lay Down ☐ Touch

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WESTON MEDICAL HEALTH CENTER *The Next Generation in Healthcare*

CONFIDENTIAL HEALTH HISORY

PHARMACY INFORMATION: Consent to Obtain RX History ☐ Yes ☐ No

(Please enter your preferred pharmacy where we should send your prescriptions-we will attempt to find it in our database.)

Pharmacy:	Address/City:	Phone:

CURRENT MEDICATION LIST: Are you taking any Medications now? ☐ NO ☐ YES

If yes, please list **name** and **dosage** of the medicine. Include prescription and over the counter:

Medication Name:	Strength	Dosage	Frequency/Take

ALLERGIES: Are you allergic to any medications? ☐ NO ☐ YES

If yes, please list:_____

SOCIAL HISTORY:

SMOKING:	Do you smoke cigarettes?	Yes	No	**# Packs/day?** ○ 1/2pk ○ 1pk ○ >1-2pks
CHEWING TOBACCO:	Do you chew tobacco?	Yes	No	
ALCOHOL:	Do you consume alcohol?	Yes	No	**Drinks per week?** ○ 1 or Less ○ 2-4 ○ >4
DRUGS:	Do you use any recreational	Yes	No	
EXERCISE:	Do you exercise?	Yes	No	**How often?** 1d/wk 2-4d/wk >5d/wk

MEDICAL HISTORY:

Have you or anyone in your immediate family (Mother, Father, Grandparents, Brothers, sisters, children) had?

Heart Disease	Yes	No	Heart Attack	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Stroke	Yes	No	Asthma	Yes	No
Hepatitis	Yes	No	Murmurs	Yes	No	Rheumatic Fever	Yes	No
Lung Disease	Yes	No	Bleeding Disorders	Yes	No	Anemia	Yes	No
Sickle Cell	Yes	No	Kidney Disease	Yes	No	Arthritis	Yes	No
Gout/pseudogout	Yes	No	Kidney Stones	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	GI Disease	Yes	No	Polio	Yes	No
Seizure disorder	Yes	No	Neuromuscular Disease	Yes	No	Psychological	Yes	No
Trauma	Yes	No	Blood clots or phlebitis	Yes	No	Blood Transfusion	Yes	No
HIV	Yes	No	Migraine	Yes	No	Osteoporosis	Yes	No

Other:_____

Please list all surgery and any periods of hospitalization (give dates):_____

_____

Do you have Advance Directives? If yes, provide copy at front desk:_____

Please list anyone you authorize Weston Medical Health Center to speak with: _____

Cancelled/Missed Appointment Policy

We want to thank you for choosing us as your health provider. In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed.

When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Please realize how important it is to keep your reserved time.
There will be a charge of $25.00 for any appointments cancelled or missed without 24 hour notice.

Thank you for your consideration of our policies and for the opportunity to be your doctor of choice.

Signature of Patient/Responsible Party_____**Today's Date** _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

I hereby request and authorize you, your employees and agents to furnish all records and reports, including x-rays and photostatic copies and any other information relating to any examination, treatment or opinion concerning any condition that I may have had in the past or now have.

Other: _____

_____

Fax Records to: 954-888-6645

Signature of Patient/Responsible Party_____Today's Date _____