Robert S. Weatherwax, D.C.
165 Sabal Palm Drive, Ste. 95
Longwood, FL 32779, USA

P: (407) 786-7246
F: (407) 786-8861
E: info@drweatherwax.com

PATIENT DEMOGRAPHIC INFORMATION

Full Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Social Security #: _____ Sex: _____ Male _____ Female

Cell Phone: _____ Home Phone: _____ Email: _____
Would you like text & email confirmations? ___ Yes ___ No If so, cell phone carrier: _____

Choose one: ____ Married ____ Single ____ Divorced ____ Minor ____ Separated ____ Partnered

Spouse's full name: _____ Spouse's contact #: _____

Whom may we thank for referring you to us? _____

IN CASE OF EMERGENCY, CONTACT: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Email: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Work Phone: _____ Job requirements/duties: _____

Address: _____ City: _____ State: _____ Zip: _____

AUTO INSURANCE

Is this injury related to an auto accident? ___ Yes ___ No If so, insurance company: _____

Claims address: _____ City: _____ State: _____ Zip: _____

Adjuster's name: _____ Policy: _____ Claim #: _____

Adjuster's phone #: _____ Adjuster's fax #: _____

HEALTH HISTORY

List any previous surgeries and major illnesses: _____

List any injuries- falls, head injuries, broken bones, and dislocations: _____

_____

Current medications: _____

Current Vitamins, Herbs or Minerals: _____

_____

Are you pregnant? ____ Yes ____ No Do you smoke? ____ Yes ____ Do you drink alcohol? ____ Yes ____ No

List any allergies: _____

Family history (i.e. Diabetes, Cancer, Heart Disease): _____

_____

Pervious Chiropractic care? ____ Yes ____ No If yes, Doctor's name: _____

PATIENT CURRENT COMPLAINT

Describe area(s) of complaint- When/How did this condition develop? _____

_____

Rate this pain on a scale from 1 (least pain) to 10 (severe pain): _____ Have you had this condition before? _____

Activity Level: ___ None ___ Light ___ Daily ___ Heavy Type of activity: ___ Running ___ Swimming ___ Biking ___ Other

Type of pain: ___ Sharp ___ Numb ___ Dull ___ Shooting __ Throbbing __ Aching __ Tingling __ Cramping __ Burning __ Other

Is this condition getting better, worse, or staying the same? _____

How often does this pain occur? _____ Is pain constant or does it come and go? _____

What aggravates your symptoms? _____

Is there anything that makes the pain feel better? _____

Does pain radiate down arms or legs? __ Yes __ No Does it interfere with: __ Work __ Sleep __ Daily Routine __ Recreation

Have you lost days from work? __ Yes __ No If so, what days? _____

What treatment have you already received for this condition? ____ Medication ____ Surgery ____ Physical Therapy ____ None

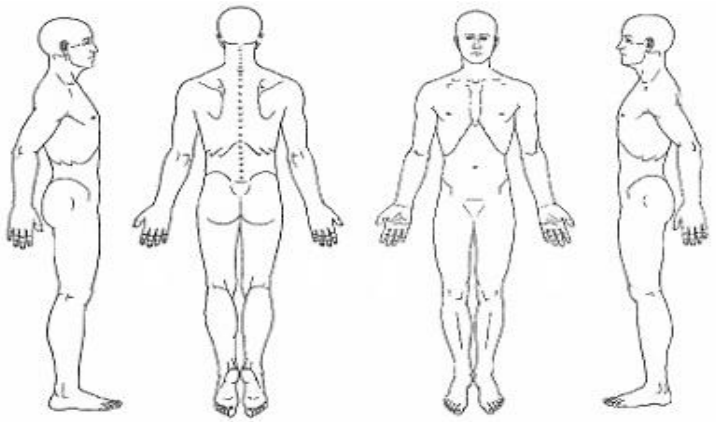
Name & contact # of other doctors who have treated this condition: _____

Fees are payable that the time examinations & treatments are received, unless other arrangements are made in advance. It is not our policy to release X-rays or MRI's that are ordered by our doctor. The films must remain at our location as part of your permanent record. We will be happy to provide you with a copy of the printed report. If the films are required by another physician or other source, copies can be made by a reputable company of our choice, but costs vary. We will be happy to give you an estimate of the cost at the time of your request. At least two weeks' notice, as well as payment in full is required when requesting films. Please sign below acknowledging that you have read and understood the information contained herein and that it has been explained to you. We are here to serve YOU, ask any questions you may have and our staff will assist you.

_____

Print Name **Signature** **Date**

On the diagram below, please indicate the exact location you are experiencing pain **(writing space for the doctor's notes)**:



Robert S. Weatherwax, D.C.
165 Sabal Palm Drive, Ste. 95
Longwood, FL 32779, USA

P: (407) 786-7246
F: (407) 786-8861
E: info@drweatherwax.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
Print Patient's Name

_____

Signature of Patient or Legal Representative **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refuse to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Robert S. Weatherwax, D.C.
165 Sabal Palm Drive, Ste. 95
Longwood, FL 32779, USA

P: (407) 786-7246
F: (407) 786-8861
E: info@drweatherwax.com

Authorization to Release, Request, or Obtain Confidential Information

By signing this authorization, I authorize First Diagnostic, Inc. to use and/or disclose certain protected health information, (PHI), about me to or for the party or parties listed below.

I, _____, Date of Birth: _____, SSN: _____
Hereby authorize First Diagnostic, Inc. to [ ] Obtain [ ] Release medical information via, mail, facsimile, or other appropriated source

[ ] To [ ] From _____
(Person(s) of Entity(s) to receive/release requested information)

_____
(Address) (City, State, Zip) (Phone number) (Fax)

I. The individually identifiable health information to be obtained/released is: (Please place a check in the appropriate space(s)).
__ Dr. Weatherwax's Office Notes __ Financial Information __ Entire Medical chart (specify if cover to cover)
__ Massage / Physical Therapy notes __ Medication List(s)
__ X-ray, Laboratory or other Diagnostic Reports _____
__ Emergency Room Records from _____ (Dates)
__ Inpatient Records _____ (Dates)
__ Only the Records from _____ to _____ (Dates)
__ Only information related to (Specify) _____
__ Other (Specify) _____

Additional information to obtain/release: (Please place a check in appropriate space(s)).

II. The Purpose or need for the disclosure of information:
____ Continuity Medical Care ____ Legal Case ____ Personal use ____ Other, please explain_____

III. This authorization will expire on _____ (please indicate expiration date or specific event).
(If authorization is not revoked and no expiration/event is noted it will terminate 1 year form the date of signature below.)

IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. My written revocation must be submitted to First Diagnostic, Inc.'s private officer at the address noted on this authorization.

I understand that First Diagnostic, Inc. may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPPA privacy rule.

I understand I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release or receipt of the information requested.

_____
(Signature of Patient of Legal Guardian) **(Relationship of Patient)** **(Date Signed)**

Robert S. Weatherwax, D.C.
165 Sabal Palm Drive, Ste. 95
Longwood, FL 32779, USA

P: (407) 786-7246
F: (407) 786-8861
E: info@drweatherwax.com

Private Pay Office Financial Policy

The purpose of the following information is to inform you of the current Financial Policies of our office. This is to assist you with any questions you may have.

In order to provide you with the best care in a cost-effective manner, our office does not bill our patients or patient insurance companies. We ask that the balance due be paid as services are rendered. Our office accepts all *local* checks, cash, and credit cards (Visa, MasterCard, Discover, and American Express) as a convenience to you.

How will you arrange payment during (invest in) your treatment within our office?

_____Cash _____ *Local* Bank Check _____ Credit/ Debit Card

PLEASE NOTE: As the patient, you are ultimately responsible for your charges. If your account reaches an unpaid balance of $100.00 or more, we (ask that your balance be paid in full within 30 days unless prior arrangements are made.) Please sign below acknowledging that you have read the above information and that it has been explained to you. We are here to serve you. Feel free to ask any questions you may have and our staff will assist you.

Patient Signature _____ Date _____

Witness Signature _____ Date _____