BOCCHINO CHIROPRACTIC NEW PATIENT INFORMATION

DATE _____ LAST NAME_____ FIRST NAME _____ MIDDLE_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ Do you wish to be notified of Saturday hours or changes to our normal hours? _____

DO YOU REQUIRE AN INTERPRETER? Yes___ No____ Language_____. (certain insurance carriers will be provided an interpreter for you).

SSN# _____ SEX M / F STATUS: M S W D BIRTHDATE____/____/____ AGE____ REFERRED BY:_____

#OF CHILDREN _____ HOME PHONE_____ CELL _____ WK PHONE_____

EMPLOYER _____ ADDRESS_____

OCCUPATION_____ HEALTH PLAN_____ ID#_____ GP#_____

SUBSCRIBER'S NAME_____ BIRTHDATE_____/_____/_____ YOUR RELATIONSHIP _____

IF YOUR CONDITION IS RELATED TO AN AUTO OR WORK ACCIDENT: CHECK ONE □ AUTO □ WORK WHEN_____

NAME OF CAR/WORKER'S COMP INSURANCE CO._____ POLICY #_____

CLAIM #_____ ADJUSTER NAME_____ TELE #_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
and assign directly to Dr. Bocchino all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Bocchino may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Date_____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

BOCCHINO CHIROPRACTIC OFFICE POLICIES AND CONSENTS

Office Policies: As a patient of Dr. Bocchino's Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. lf I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.

Consent for X-Ray (lf needed): I authorize Dr. Bocchino, D.C. to do an X-Ray examination if needed.

Notice of Privacy Practices : Please choose the method by which you wish to receive the Notice of Privacy Practices :
____ by email at _____ OR _____ paper copy OR _____ I don't wish to receive the Notice of Privacy Practices at this time and acknowledge that a copy will be provided to me at any time, and one is also available in the reception area and at BocchinoChiropractic.com for viewing at any time.

***Females: Are you pregnant at this time? (No) (Yes) (Maybe) Date of last menstrual period:**_____
Regarding diagnostic x-rays (if necessary), I acknowledge that I am **not pregnant**, nor am I trying to get pregnant. X-ray radiation is dangerous to a developing fetus. If I suspect that I may be pregnant, I have made the doctor aware of this so that x-rays are not performed.

I _____ (print name) have read and fully understand the above statements.

Signature: _____ Date:_____

INITIAL HEALTH STATUS

Patient Name:_____ Date Problem Began_____ How Problem Began_____

Describe Your Current Problem: ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other_____

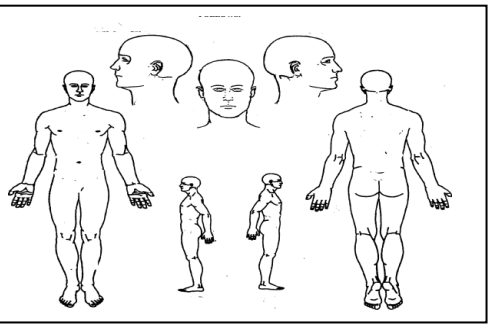
Is this: ☐ Work Related ☐ Auto Related ☐ N/A

Mark an "X" on the picture where you have pain or symptoms

Current complaint (how you feel today):

No Pain _____ Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10



How often are your symptoms present?

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores?

No Interference 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐Thyroid ☐ Heart Problems/Stroke ☐ Arthritis

Describe your <u>current</u> pain/symptoms:

☐ Sharp/Stabbing ☐ Throbbing ☐ Aches
☐ Dull ☐ Soreness ☐ Weakness
☐ Numbness ☐ Shooting ☐ Gripping
☐ Burning ☐ Tingling ☐ Other_____

HAVE YOU HAD SPINAL: □ X-RAYS, □ MRI, □ CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

What area(s) were taken?_____ Date Taken_____ Taken By_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date) _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight □ Gain □ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
☐ Tobacco Use – Type_____
Frequency_____ / Day

Medications_____

Allergies_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractic may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature:_____ Date:_____

BOCCHINO CHIROPRACTIC

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that I have the right to refuse to sign this acknowledgement.

I, _____, have received a copy of the Notice of
(PLEASE PRINT NAME)

Privacy Practices for the above referenced practice.

_____ _____
(SIGNATURE) (DATE)

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices from the above individual, but acknowledgement could not be obtained because:

- ❑ The individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency situation prevented us from obtaining acknowledgement.
- ❑ Other reason, as follows: _____

_____

_____

Bocchino Chiropractic

Dr. Anthony Bocchino
17897 MacArthur Blvd., Suite 101
Irvine, California 92614

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Bocchino and/or other licensed doctors of chiropractic (hereafter referred to as "the chiropractor") who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Bocchino, including those working at this facility.

The chiropractor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

As with any health care procedure, there are "material risks of proposed care. "Material" shall be defined as a procedure inherently involving known risks of serious bodily harm. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

In signing this informed consent form, I affirm that I have read, or have had read to me, the above consent in its entirety and that the chiropractor has verbally explained the contents herein and that I understand the nature of the chiropractic treatment. I also affirm that all my questions regarding the chiropractic treatment, the management of my case, and the related risks to chiropractic treatment has been answered to my satisfaction.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

_____	_____
Print Patient's Name	Date
_____	_____
Signature of Patient	Signature of Patient's Representative (If a minor or incapacitated)