BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

Please allow our staff to make a copy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)_____ Whom may we thank for referring you? _____

PERSONAL

Last Name_____ First_____ Middle(or Initial) _____

Street Address _____

City _____ State/Province_____ ZIP/Postal Code_____

Home Phone _____ Cell _____ Email Address _____

Gender ○Male ○Female Birth Date (MM/DD/YYYY) _____ Social Security Number _____

Marital Status ○Single ○Married ○Divorced ○Widowed ○Separated Spouse's Name _____

Other Family Members _____

Occupation _____

Employer _____ Phone _____

Preferred method of contact ○Home Phone ○Cell Phone ○Work Phone ○Email

Primary Care Physician _____ Phone_____

Emergency Contact _____ Phone Number _____

INSURANCE

Insurance Carrier_____ Policy Number _____ Carried by ○Self ○Spouse ○Parent

Insured's Last Name _____ First_____ Middle Initial)_____

Insured's Birth Date (MM/DD/YYYY) _____ Social Security Number _____

Insured's Employer _____ Phone _____

Street Address _____

City _____ State/Province_____ ZIP/Postal Code_____

PREVIOUS CHIROPRACTIC CARE

Have you seen a Chiropractic Physician before? ___ Yes ___ No

Who? _____ When? _____

Reason for Visit at that time: _____

How did you respond? _____

Name: _____ Date: _____

The symptom(s) that have prompted me to seek care include: _____

_____

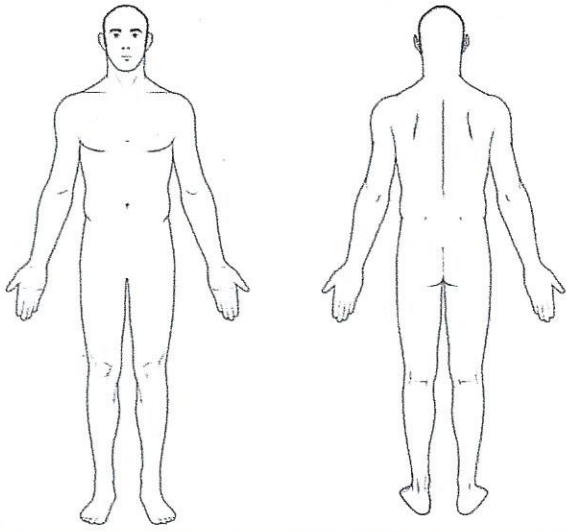
And are the result of: ❍Work Injury ❍Auto Accident ❍Wellness ❍Other _____

Onset: When did your symptoms begin _____ Intensity: How much pain does it cause? 0 1 2 3 4 5 6 7 8 9 10
No pain moderate severe

Duration and timing: How often do you feel your symptoms? ❍Constant ❍Comes and goes How often? _____

Symptoms: What does it feel like? Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting Throbbing Stabbing Other: _____

Location: Were does it hurt? Circle area(s) on the illustration.
X for current condition, **O** for conditions experienced in the past.



What areas, if any, does the pain radiate, shoot or travel?

_____

Aggravating/relieving factors: What makes it better or worse, time of day, movements, certain activities, etc.?

What makes the pain **worse**?

_____

What makes the pain **better**?

_____

What previous treatments have you done for this condition?

_____

_____

What else should the Doctor know about your current condition?

_____

Activity	Pain	No	Mild	Moderate	Severe
Sitting		❍	❍	❍	❍
Rising out of chair		❍	❍	❍	❍
Standing		❍	❍	❍	❍
Walking		❍	❍	❍	❍
Lying down		❍	❍	❍	❍
Bending over		❍	❍	❍	❍
Climbing stairs		❍	❍	❍	❍
Using a computer		❍	❍	❍	❍
Getting out of car		❍	❍	❍	❍
Driving car		❍	❍	❍	❍
Looking over shoulder		❍	❍	❍	❍
Caring for family		❍	❍	❍	❍

Activity	Pain	No	Mild	Moderate	Severe
Grocery Shopping		❍	❍	❍	❍
Household chores		❍	❍	❍	❍
Light Lifting		❍	❍	❍	❍
Reaching Overhead		❍	❍	❍	❍
Showering/bathing		❍	❍	❍	❍
Dressing self		❍	❍	❍	❍
Getting to sleep		❍	❍	❍	❍
Staying asleep		❍	❍	❍	❍
Concentrating		❍	❍	❍	❍
Exercise		❍	❍	❍	❍
Yard Work		❍	❍	❍	❍
Intimacy	❍	❍	❍	❍	

Family History:

Relative	State of Health Good	Poor	Age	Illnesses	Age at death	Cause of death
Mother	❍	❍				
Father	❍	❍				
Sister 1	❍	❍				
Sister 2	❍	❍				
Brother 1	❍	❍				
Brother 2	❍	❍				
_____	❍	❍				

Are there any other hereditary health issues of which you are aware? _____

Name _____ Date _____

MEDICAL HISTORY

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependance
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss	☐	☐	Ankle/Foot Pain
☐	☐	Loss of Appetite	☐	☐	Jaw Pain	☐	☐	Abdominal Pain
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Arthritis
☐	☐	Hepatitis	☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer	☐	☐	General Fatigue	☐	☐	Tumor
☐	☐	Muscular Incoordination	☐	☐	Asthma	☐	☐	Visual Disturbances
☐	☐	Chronic Sinusitis	☐	☐	Dizziness	☐	☐	Other _____

For Females Only: Birth Control Pills Hormonal Replacement Pregnancy

List all prescription medications you are currently taking _____

List all the over-the-counter medications you are currently taking _____

List all Supplements and Herbs _____

List all surgical procedures you have had _____

Social History:

Alcohol Use	○Daily	○Weekly	○Occasional	How much?	_____
Coffee Use	○Daily	○Weekly	○Occasional	How much?	_____
Tobacco Use	○Daily	○Weekly	○Occasional	How much?	_____
Exercising	○Daily	○Weekly	○Occasional	How much?	_____
Pain Relievers	○Daily	○Weekly	○Occasional	How much?	_____
Water Intake	○Daily	○Weekly	○Occasional	How much?	_____

Hobbies: _____

Mercury Filling Yes No

Recreational Drugs Yes No

Daily Living:

How much sleep are you getting per night? _____Hours Preferred Sleeping Position: ○ Back ○ Side ○Stomach

Typical Eating Habits: _____

In addition to the main reason for your visit, what are your other health goals? _____

Name _____ Date _____

ACKNOWLEDGEMENTS

In order to set clear expectations, improve communication and help you attain the best results, please read each statement and initial your agreement.

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered at Health Loft Chiropractic is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) _____

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information, as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services that I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date

Insurance Policy and Fee Schedules

- Consultation includes practice member history. This is a complimentary service.
- Examination (new patient and established patient) includes one or more of the following: range of motion, motion and/or static palpation, muscle testing, dermatome testing, and leg check.
- Chiropractic Adjustment, this is the actual realignment of the vertebra, a manual or specific instrument spinal adjustment will be delivered to help re-align the vertebra.
- X-rays may be taken with specific views of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to help indicate progress after a period of care.

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to *Dr. Benjamin L. Naar* I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for the service when rendered unless other arrangements have been made in advance. I understand that I am Financially responsible for any charges not covered by this assignment.

_____ _____

Signature Date

BENTIN CHIROPRACTIC

7545 W, Boynton Beach Blvd., Suite. 102
Boynton Beach, FL 33437
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Social Security _____

SECTION B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a reversed Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Bentin Chiropractic Wellness Center
7545 W, Boynton Beach Blvd., Suite. 102
Boynton Beach, FL 33437

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

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RELEASE OF MEDICAL RECORDS:

I am requesting that my medical records be released to:

Bentin Chiropractic Wellness Center
7545 Boynton Beach Blvd. Suite 102
Boynton Beach, Florida 33447
Phone: 561-736-9355 Fax: 561-736-6661

Patient Signature:_____

Date: _____

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FINANCIAL POLICY

Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify your chiropractic benefits and file claims to your insurance company. Verification of your insurance is not a guarantee of benefits or payment. Your insurance company will make the final determination of your eligibility and subsequent payments

Payments: A payment is due to your account on the date of service unless other written arrangements have been approved. If there is a balance on your monthly statement, payment is due within 30 days unless other written arrangements have been approved. If no payment is made after 60 days or more, we will take necessary steps to collect this debt. If we refer your account to a collection agency, there will be an additional collection agency fee added to your balance.

Returned Checks: There will be a $12.00 fee assessed for all returned checks.

I have read and understand the financial policy and agree to all terms and conditions stated herein. I agree to make payments on my account on each date of service unless other arrangements have been made.

Patient's Name: _____

Patient Signature: _____

Responsible Party (if not the patient): _____

Date: _____