CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

Patient Name _____

_____

Address _____

City _____

State _____ Zip _____

Email _____

Social Security # _____ - _____ - _____

Sex ☐ M ☐ F Age _____

Birth date _____

Marital Status

☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Minor ☐ Single ☐ Partnered for _____ years

Occupation _____

Patient Employer/ School _____

Employer/ School Phone (_____)_____

Primary Doctor _____

Whom may we thank for referring you

☐ Walk-in ☐ Insurance ☐ Gift card ☐ Attorney

☐ Former Patient: _____

Internet: ☐ Google ☐ Yelp ☐ Website

☐ Other: _____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Policy ID _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth date _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I, and my dependant(s), have insurance coverage with _____ and assign directly to Dr. Colaizzo all insurance benefits, if any, otherwise payable to me for service 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.

The above named doctor may use my health care information and may disclose such information to the above name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to patient

PHONE NUMBERS

Home Phone (_____)_____

Cell Phone (_____)_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone (_____)_____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes, Date _____ ☐ No

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto insurance ☐ Employer ☐ Workers Comp. ☐ Other

Attorney name (if applicable): _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of the pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

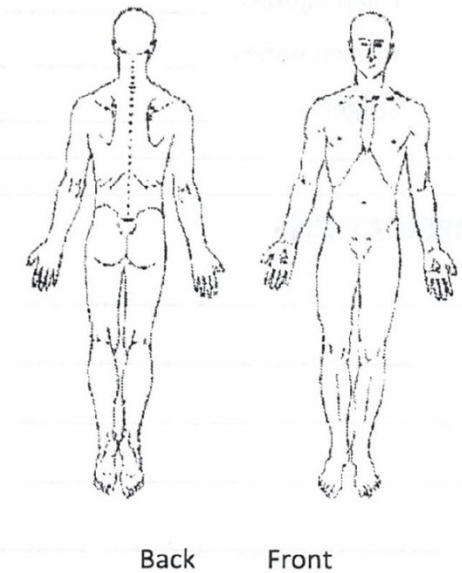
How often do you have this pain? _____

Is it constant of does it come and go? _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying down



HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and addresses of other doctor(s) who have treated you for your condition _____

_____

Date of last: Physical exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental X-ray _____ MRI, CT-scan, Bone scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated disc	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Prostate Problems	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking — Packs/ Day _____
☐ Alcohol — Drinks/ Week _____
☐ Coffee/ Caffeine drinks — Cups/ Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ No ☐ Yes, Due Date _____

Injuries/ Surgeries you have had

	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____

MEDICATIONS
_____
_____
_____
_____
_____

ALLERGIES
_____
_____
_____
_____
_____

VITAMINS/ HERBS/ MINERALS
_____
_____
_____
_____
_____

HIPAA 2024

Catherine Colaizzo, D.C. 1075 Easton Ave. Somerset, NJ 08873

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient here we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: US DEPT of Health & Human Services.

This notice is effective as of Jan 1, 2014. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Printed) date Signature Parent or Guardian

Coronavirus (COVID_19) Screening Questionnaire

Patient Name: _____ Today's Date: _____

Patient DOB: _____ Age: _____

1) Have you traveled anywhere in the last 3 weeks (especially outside the USA)?
   NO____ YES ____ If yes please explain.

_____
_____

2) Have you been in contact with anybody that was sick in the last 3 weeks?
   NO____ YES ____ If yes please explain (this could be a friend, family or co- worker).

_____
_____

3) Have you been to a region designated as an epicenter (AREAS OF HIGH CONTAGION)?

   NO___ YES____ If yes please explain.

_____
_____

4) Do you have symptoms of a cold or flu? YES____ NO____
5) Do you have a cough? YES____ NO____
6) Do you have any difficulty breathing? YES____ NO____
7) Do you have a runny nose? YES____ NO____
8) Do you have a sore throat? YES____ NO____
9) DO you have any illness related body aches? YES____ NO____

I attest that I have fully and properly answered the above questions and the information is complete.

Patient's/ Guardian's Signature: _____ Date: _____

-Chiropractic & Therapy Center-
Catherine Colaizzo, D.C.

Date: _____

Authorization to Release Medical Information

I hereby authorize the following healthcare provider to release and/or exchange my personal medical records between all relevant medical providers and attorneys (where applicable) on my behalf. Information exchanged can include but is not limited to: office notes, exam reports, diagnostic tests, referrals, billing records, insurance records, and records furnished by other healthcare providers.

Chiropractic and Therapy Center
Catherine Colaizzo, DC
1075 Easton Avenue Suite 9
Somerset, NJ 08873
Phone (732) 545-5999
Fax (732) 545-3439

Patient name (printed) _____

Patient DOB: _____

Patient Signature: _____

Date of signature :_____