WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

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REASON FOR VISIT

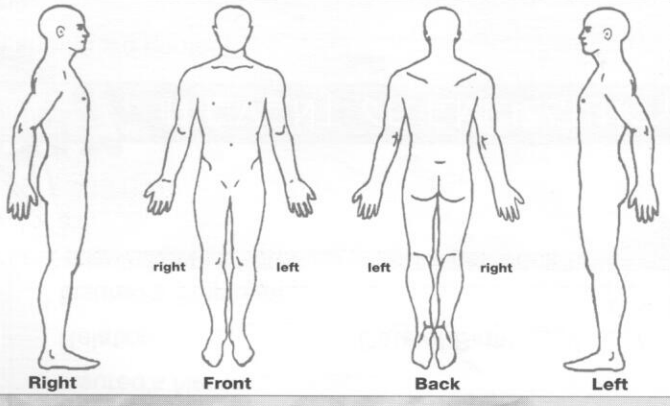
Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



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HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials	Date
	___/___/___

Comments

Initials	Date
	___/___/___

Comments

Initials	Date
	___/___/___

Comments

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

BODY CHART

REASON FOR VISIT

Name: _____ Date: __/__/__ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Reason for visit: ❑ Work Accident ❑ Sports Injury ❑ Car Accident ❑ Trauma/Injury ❑ Chronic Pain ❑ Routine Adjustment

Explain what happened: _____

When did condition begin? __/__/__ Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine Have you had this or similar conditions in the past? ❑ Yes ❑ No

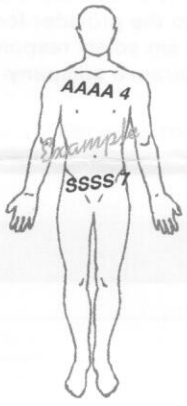
If so, please explain: _____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

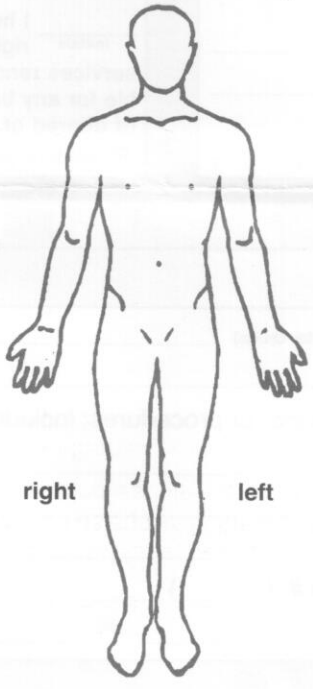
Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.

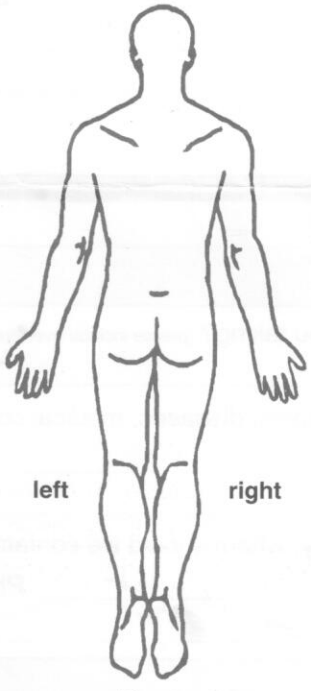


Example

Right



Front



Back

Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

WELCOME TO THE OFFICE OF DR. JOHN GIUGLIANO

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we begin any health care plan, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment and coordination of care.
2. I understand that the office of John Giugliano, D.C., P.C. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out my treatment, payment and coordination of care, such as appointment reminders, patient recall, insurance items and any call pertaining to my clinical care. I also understand that John Giugliano, D.C., P.C. may mail or email to my home or other designated location any items that assist the practice in carrying out my treatment plan, payment and coordination of care, such as appointment reminder cards and patient statements. My consent need only be obtained one time for all subsequent care rendered to me in this office.
3. If I was referred to this office by a third-party, I understand that a thank you letter may be sent to that individual.
4. I understand that my records will be kept on premise with the exception that they may be stored in an offsite facility or utilized by office personnel at another location. My records will never be left in an unsecured location or be used for any purpose other than what is stated above.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. By signing this form, I am consenting to John Giugliano, D.C., P.C.'s use and disclosure of my Patient Health Information in this manner.

Print Name_____ Date_____

Patient Signature_____

WELCOME TO THE OFFICE OF DR. JOHN GIUGLIANO

Financial Policy

Thank you for choosing the office of Dr. John Giugliano as your health care provider. For our part, our primary goal is to provide you with the highest quality chiropractic care. Your part is to read and sign the following financial policy. This policy is to insure that there is no misunderstanding or confusion as to your financial responsibilities.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH AND PERSONAL CHECK

INSURANCE PATIENTS

If we are a participating in-network provider with your insurance company, all insurance copays and/or applicable deductibles are to be paid at the time of service.

If we are accepting your insurance as an out-of-network provider, you will be responsible for any applicable deductibles and/or coinsurance to be paid at the time of service.

It is your responsibility to obtain any required referrals prior to your first visit. If a referral was required but not obtained, you will be fully responsible for all fees incurred.

Some insurance carriers require authorization for your initial visit and/or subsequent visits. This office will obtain any authorization required by your insurance carrier regarding your care. If during the course of treatment your insurance carrier denies authorization, you will be responsible for a set fee for non-covered services. We will always try to inform you if your insurance carrier has failed to authorize your treatment as soon as possible.

With regards to no-fault insurance, under New York State Law, a $200.00 deductible ***may*** be applicable to your treatment in this office.

NON-INSURANCE PATIENTS

Patients are responsible for initial exam fees and radiology (if applicable), and any subsequent visits. All payments are due at the time of service.

If you wish to request any financial arrangements, you may do so directly with our office manager, Deborah, not with the front desk staff or the doctor.

APPOINTMENT CANCELLATION

If for any reason you cannot keep your scheduled appointment, kindly notify our office within 24 hours.

* * * * * *

It is this office's pledge to assist you in understanding your insurance policy and how it affects your care. Please do not hesitate to ask for clarification of your coverage.

I have read, understand and agree to the financial policy as stated above.

_____ _____

Patient Signature or Responsible Party **Date**