CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

PATIENT INFORMATION:

First/Last Name: _____ Nickname: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #:_____ Cell Phone #: _____ Work #: _____

Age: _____ Date of Birth: _____ Marital Status: ☐ M ☐ S ☐ D ☐ W

E-mail address: _____

Is your visit due to an accident? ☐ No / ☐ Yes-Motor Vehicle / ☐ Yes-Other Accident

Are you a Medicare patient? ☐ No / ☐ Yes Medicare #: _____

PRIMARY CARE PHYSICIAN:

Name: _____ Telephone Number: _____

Address: _____

EMPLOYMENT INFORMATION:

Your Occupation: _____ Employer: _____

Employer Street Address: _____

Employer City, State, Zip Code _____Work Phone #: _____

SPOUSE INFORMATION:

Your Spouse's Name: _____

Spouse's Contact #: _____

EMERGENCY CONTACT /FAMILY INFORMATION:

Name of person(and relationship) to contact in case of emergency:

_____

Emergency contact phone number(s): _____

Name of nearest relative (and relationship) not living with you / phone number(s):

_____

REFERRAL INFORMATION:

Who referred you to this office so we may thank them? _____

In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultation without charge. If the doctor might be able to help you with your condition, are you interested in seeking care?

☐ Yes ☐ Unsure

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient or Guardian Signature: _____ Date: _____

Parent or Guardian Name: _____

Patient Number: _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities. Any other disclosure for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosure that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Chiropractic Director, Dr. B.B. Berger D.C. This notice is effective September 1, 2003.

Name_____ Date of Birth_____

Signature_____
Patient / Guardian Signature

Insurance Information (complete only if insurance card not provided at check-in)

Company Name_____ Work Phone_____

Address_____
Street or Box Number City State Zip

Employer_____ Address_____

Occupation_____ Phone Number_____

Patient Number: _____

PATIENT CONSENT AUTHORIZATION

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Assignment of Benefits: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment and for all charges that the insurance carrier declines to pay.

Release of Information: the physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O. Disclaimer: I certify that if I am presently enrolled in a Health Maintenance Organization (HMO) plan I am responsible for obtaining the necessary pre-authorizations and referrals. Subsequent rejection of an HMO claim will constitute responsibility for payment of the total claim amount billed.

Medicare Patient Certification – Patients Certification Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits to be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Verification of Non-Pregnancy (Female Patients Only): By my signature on this form I do hereby state that to the best of knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Consent to Treatment of Minor Child: If applicable: I hereby authorize the clinical and ancillary staff of Highland Park Wellness & Rehab to administer as they so deem necessary to my child.

_____
Printed Patient's Name

_____ _____
Patient's Signature Date

_____ _____
Guardian Name (Printed) Relationship to Patient

_____ _____
Guardian Signature, if patient is a minor Date

_____ _____
Witness Date

Patient Number:_____

HIGHLAND PARK WELLNESS & REHAB - Dr. Burton Berger, D.C.
5634 Dyer St ● Dallas, Texas 75206 ●214-219-3900●214-219-1207 (fax)
www.highlandparkwellness.com

FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefit directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family budget. Any personal balance not paid by Friday is automatically charged to your designated card.

2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget. Any personal balance not paid by Friday is automatically charged to your designated card.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with an itemized statement for your secondary carrier.

The Undersigned has made, constituted and appointed, any these presents does hereby make Highland Park Wellness & Rehab and any of its duly authorized agents and employees as to be the undersigned's true and lawful Attorney in Fact for and in the undersigned's name, place and stead to endorse any all checks, drafts or money orders which are payable for services rendered in the office of Highland Park Wellness & Rehab.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

3. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

I have read and fully understand the financial policy of Highland Park Wellness & Rehab.

Signature:_____Date:_____

Witness:_____Date:_____

I agree to the above terms and authorize you to bill the charge card indicated. I understand that should payment not be received within sixty (60) days after submission of my claim, or should I terminate care before being dismissed by my provider, I will be charged the amount due.

For your convenience you **MAY** retain your credit card number on file with us.

CREDIT CARD: AMEX VISA MC DISCOVER
Name as it appears on card:_____

Card #_____Exp. Date:_____ Auth Code: _____ Billing Zip Code:_____

Signature:_____Date:_____

Patient Name _____ Date _____ Number _____

REVIEW OF SYSTEMS: Check only the ones you now have or have had in the past.

GENERAL	Now	Past
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam____		
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	Now	Past
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble	☐	☐
Swallowing	☐	☐
Recurrent	☐	☐
Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen	☐	☐
Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	Now	Past
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY	☐	☐
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color _____		
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____

Age at 1st Period _____

Duration of Cycle _____

Duration of Flow _____

# of Pregnancies _____

# of Births _____

# of Miscarriages _____

# of Abortions

Menstrual Flow ☐Heavy ☐Mod ☐Light

Last Period _____

Last Pap Smear _____

Last Vaginal Exam _____

Last Mammogram _____

Last Prostate Exam _____

Patient Name _____ Date _____ Number _____

REVIEW OF SYSTEMS: Check only the ones you now have or have had in the past.

NEUROLOGIC	Now	Past
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficult Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

PSYCHIATRIC	Now	Past
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	Now	Past
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION		
DPT	☐	☐
Mumps	☐	☐
Smallpox	☐	☐
Typhoid	☐	☐
Tetanus	☐	☐
Measles	☐	☐
Pneumococcal	☐	☐
Influenza	☐	☐
Polio	☐	☐
MMR	☐	☐
Shingles	☐	☐
COVID-19	☐	☐

PAST MEDICAL HISTORY, Check only the ones you have had in the past.

Hay Fever	☐		Epilepsy	☐	
Mumps	☐		Paralysis	☐	
Rheumatic Fever	☐		Polio	☐	
Allergies	☐		Mental Illness	☐	
Angina	☐		Alcoholism	☐	
Cancer	☐		Depression	☐	
Tumor	☐		Nervous Breakdown	☐	
Blood Disease	☐		Migraine	☐	
Leukemia	☐		Gout	☐	
Heart Trouble	☐		Hemorrhoids	☐	
Varicose Veins	☐		Prostate Problems	☐	
Phlebitis	☐		Sexual Problems	☐	
Hypertension	☐		Gonorrhea	☐	
Stroke	☐		Syphilis	☐	
Ulcers	☐		Diabetes	☐	
Jaundice	☐		Bladder Trouble	☐	
Skin Trouble	☐		Kidney Stones	☐	
Gallstones	☐		Kidney Infections	☐	
Liver Trouble	☐		Diabetes	☐	
Hepatitis	☐		Bladder Trouble	☐	
Parasites	☐		Dysentery	☐	

BLOOD TYPE

A +	☐	A -	☐
B +	☐	B -	☐
AB +	☐	AB -	☐
O +	☐	O -	☐

Other: _____

BLOOD TRANSFUSIONS

Date _____

Date _____

Date _____

Date _____

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal

Last TB Skin Test _____ ☐ Normal ☐ Abnormal

Allergies _____

_____

_____

MEDICATIONS / SUPPLEMENTS: (list all current prescriptions, over the counter medications, vitamins and supplements)

_____

_____

_____

_____

Patient Name _____ Date _____ Number _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight: _____ Have you recently lost or gained weight? _____

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week _____ Type _____

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of Years _____

Alcohol Beer/Week _____ Liquor/Week_____ Wine/Week _____ No. of Years _____

Caffeine (Coffee, Tea, Cola) Cups / Day _____ No. of Years _____

Aspirin No./Day_____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles ●●●● Stabbing ////

MARK AN "X" ON THE LINES:
How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe