Casey Family Chiropractic, PLLC

Dr. Brian T. Casey
68 E. Main St. Washingtonville, NY 10992

1 PLEASE TELL US ABOUT YOU...

Today's Date _______ /________/____________

Who May We Thank for Referring You to Our Office?

____

Your Name _____________________________________
◯ Male ◯ Female

Birthday ________ /_______ / ________ Age ___________

E-mail: ____

@ ____

Home Address ___________________________________
Street Apt. #

____
City State Zip Code

Home Phone #: (_______)___________________________

Mobile Phone# (_______) __________________________

Work Phone #: (_______)___________________ Ext. _______

Occupation: ____________________________________

Employer's Name: _______________________________

Address _______________________________________
Street Bldg. # Floor

____
City State Zip Code

Marital Status:
◯ Single ◯ Married ◯ Divorced/Separated ◯ Widowed

Spouse and Children's names & ages ____________________

____

In case of emergency, whom should we contact?

____
Name Relation

(______)____________________(______)_________________
Daytime Phone Number Evening Phone Number

Acct #: ___________________________

2 YOUR CURRENT HEALTH GOALS...

Please check the choice(s) that most closely describe you:

◯ I am only concerned with the relief of a particular symptom.

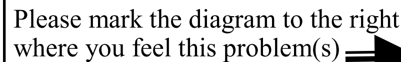
◯ I am concerned about relief of a particular symptom, and preventing it's return.

◯ I want to perform at my highest capacity.

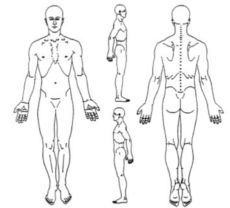
3 PLEASE TELL US THE REASON FOR YOUR VISIT TODAY...

Please tell us the reason for your visit with the specific area of complaint :_________________________________

____



Please mark the diagram to the right where you feel this problem(s)



For how long? ______________
(days, weeks, months, years)

What have you tried to do regarding this condition?
(pain meds, PT, massage, etc.)

____

Pain Scale, please circle (0= No pain, 10= Unbearable pain)
0—1—2—3—4—5—6—7—8—9—10

Have you seen a chiropractor before? ◯ Yes ◯ No

How long ago? __________ Same condition? Y / N

What medications are you presently taking? ___________

____

Do you have any other health concerns? _______________

____

"PLEASE CONTINUE ON THE BACK"

4 GETTING TO KNOW YOU...

To help us better explain your chiropractic condition and how we may best serve you, please answer the following questions.

1 Please list the 3 things in your life that are most important to you
A. ____________________________________
B. ____________________________________
C. ____________________________________

2 I remember important things in my life by ***(choose one)*:**

◯ What I see ◯ What I hear ◯ How I feel

3 The primary reason I brush my teeth is to ***(choose one)*:**

◯ Avoid tooth decay and gum disease
◯ Make sure I have healthy teeth and gums

4 When I make decisions, I generally:

◯ Gather facts and weigh the evidence
◯ Make my choice instantly
◯ Consult my family and friends
◯ It depends on how I feel about it

5 Please share any hobbies and activities that you like to do that have been affected by your present state:

____
____
____

5 INSURANCE INFORMATION

Please present your insurance card(s) to the front desk

Primary Insurance Company

Company Name ____________________ Primary insured ___________________ DOB ____/____/_____ Relation: ___________________

Secondary Insurance Company

Company Name ____________________ Primary insured ___________________ DOB ____/____/_____ Relation: ___________________

I authorize any holder of medical or other information about me to release to my doctor, health insurance carrier or their intermediaries, any information necessary for my medical care or to process this or any related health insurance claim. I hereby authorize payment of benefits to be made directly to Dr. Brian T. Casey, I permit a copy of this authorization to be used in place of the original. I understand that all fees for service rendered are my responsibility regardless of my insurance coverage. This office may elect to accept benefits assigned on a case-by-case basis. All fees not paid by my insurance carrier are to be paid in full by me. Our office policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. I understand that if the account is not paid within thirty (30) days, I will be responsible for any expenses incurred in collecting my account, including but not limited to, referral to a collection agency. I understand it is my responsibility to inform this office of any change in my personal information. (i.e. address, phone number, insurance information, medical or health status.)

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION."

_________________________ _________________________ ________/______/________
(print name) *(signature)* *(date)*

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE SPEAK TO US BEFORE SIGNING THIS DOCUMENT.

_________________________ _________________________ ______/_____/_______
(doctor's name) *(signature)* *(date)*