FAKHOURY MEDICAL AND CHIROPRACTIC CENTER

1009 SW 16th Lane Ocala, FL 34471

Account# _____

PLEASE PROVIDE US WITH YOUR DRIVER'S LICENSE AND INSURANCE CARD

Name: _____ Nickname: _____

Address: _____ ☐ Male ☐ Female

City /State/ Zip: _____

Birth date: _____/_____/_____ Age: _____ SS#: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ E-mail address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Telephone#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____

Ethnicity: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Other_____

☐ Decline to answer

Which of the following activities aggravate your condition: (Please check all that apply)

☐ Standing ☐ Sleeping ☐ Twisting ☐ Sitting ☐ Bending ☐ Lifting ☐ Walking

☐ Sneezing ☐ Coughing ☐ Lying Down ☐ Sexual Activity ☐ Other_____

Are the symptoms: ☐ Improving ☐ Getting Worse ☐ About the Same ☐ Intermittent (come & go)

I clearly understand that if I am accepted as a patient at Fakhoury Medical and Chiropractic Center, I authorize them to proceed with the treatment as necessary. Any risks regarding such treatment will be explained upon request. I also understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. In the case insurance verification is obtained, insurance claims may be filed. I understand that the filing of insurance is not a guarantee of payment, and I remain responsible for the entire amount due. I also understand that if I terminate my care and treatment, any fees for professional services rendered me prior to my termination of care will be immediately due and payable. In the extent of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I hereby attest that the above and all following information is true to the best of my knowledge.

_____ _____ _____ _____

Signature of Patient or Patient's Guardian Date Witness Date

Please let our staff know if you have any questions or need assistance, we are here for you.

Patient Name:_____ **Acct#**_____ **Date:**_____

TODAY'S CHIEF COMPLAINT:_____

Is this condition due to: ☐ Auto Accident ☐ Work Related ☐ Fall ☐ Other_____

Date of Accident:_____ Were you treated at the ER?_____ Name of Facility:_____

Were MRIs, CTs, Ultrasounds or Xrays done?__ Where?_____

Primary Care Physician:_____ Phone:_____

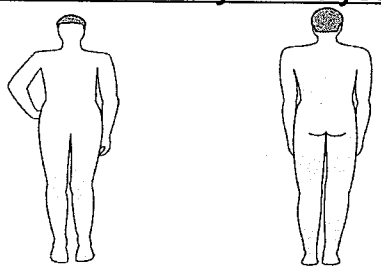
Have you seen another Doctor for this condition?____ Name of Doctor:_____

Have you had any Xrays, MRIs, CTs or Ultrasounds for this condition?_____ Where?_____

Do you have an Attorney representing you?_____ Name: _____

Work History: Describe your job duties_____ Employer:_____

Mark an X on the body where you feel pain.



Medications?:_____
Allergies?_____

Past Medical History:
Have you had any of the following problems (check all that apply)

☐ Asthma	☐ Bowel disorder	☐ Kidney disease	☐ Rheumatism	☐ Bladder Disorder
☐ Heart disease	☐ Depression	☐ Bronchitis	☐ Mental Illness	☐ Lung disease
☐ High Blood pressure	☐ Stroke	☐ Polio	☐ Seizure	☐ Tuberculosis
☐ Thyroid	☐ Ulcer	☐ Diabetes	☐ None	☐ Other_____

Past Surgical History:_____

Family History: **Do you have a family history with any of the following (check all that apply)**

☐ Diabetes	☐ Hypertension	☐ Cancer	☐ Heart Attacks	☐ Tuberculosis
☐ Arthritis	☐ Back problems	☐ None	☐ Other _____	

Social History: Answer the following:

Smoker? Y N	Alcohol use? Y N	Caffeine? Y N	Exercise? Y N	Drug use? Y N
____Packs per day	____drinks per week	_____ per day	_____ per week	_____ per week

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information "protected health information" by Fakhoury Medical and Chiropractic 1009 SW 16th Lane Ocala FL 34471, in order to carry out treatment, payment, or health care operations. The Patient should review FMCC's Notice of Privacy Practices for Protected Health Information "attached" for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

FMCC reserves for itself, the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the FMCC does change the terms of its Notice of Privacy Practices, The patient may obtain a copy of the revised Notice by written request.

Patient retains the right to request that FMCC further restricts how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. FMCC is not required to agree to such requested restrictions; however, if FMCC does agree to Patient's requested restrictions, such restrictions are then binding on the FMCC.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the FMCC in writing. The revocation shall be effective *except* to the extent that the FMCC has already taken action in reliance on the Consent.

FMCC may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the FMCC is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the FMCC has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the FMCC is required by law to treat individuals).

I wish to have the following restrictions to the use or disclosure of my health care information:

_____

_____

_____

I HAVE READ, ACCEPTED AND I UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ Date:_____

Signature of Patient

_____

Please print name

_____ Date _____

Signature of witness

Review of Systems

Patient Name:_____ Acct.#_____ Date_____

Please check ALL symptoms you have recently experienced:

I. HEENT - ☐ double vision
☐ blurred vision
☐ ringing in the ears
☐dizzy
☐ poor hearing
☐severe headache
☐severe recurrent nose bleed
☐difficulty swallowing

II. CARDIOPULMONARY
☐dull chest pain
☐pressure/tightness
☐chest palpitations (fluttering)
☐shortness of breath at rest
☐shortness of breath with exertion
☐shortness of breath when lying flat
☐coughing
☐coughing up blood
☐swelling feet
☐severe sweating at night

III. GASTROINTESTINAL
☐abdominal pain
☐vomiting
☐vomiting blood
☐black & tarry stool
☐ bloody stools
☐clay colored stools
☐loss of bowel control
☐dramatic change in bowel habits
☐jaundice(yellowing of skin, eyes)

IV. GENITOURINARY
☐burning on urination
☐blood in urine
☐urinary frequency
☐loss of bladder control
☐penile or vaginal discharge
☐penile or vaginal bleeding
☐genital sores

V. MUSCULOSKELETAL
☐joint pain
☐ joint swelling
☐grinding of joints
☐locking of joints
☐ neck pain
☐ back pain

VI. CONSTITUTIONAL
☐fever
☐chills
☐night sweats
☐loss of appetite
☐unintentional weight loss

VII. CNS
☐paralysis in arms or legs
☐numbness in arms or legs
☐ loss of consciousness
☐seizures
☐tremors
☐jerking
☐poor coordination

VIII. SKIN
☐loss of hair
☐dry sores_____location
☐itchiness
☐rashes

IX. ENDOCRINE
☐increase thirst
☐excessive urination
☐excessive drinking
☐hot/cold intolerance
☐excessive sweating

_____
Patient Signature

Pain Disability Questionnaire

Patient: _____ **Acct#** _____ **Date:** _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel. TEN being the Highest level of pain reached

1. Has your pain interfered with your normal work inside and outside the home?
   Work normally — Unable to work at all
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
2. Has your pain interfered with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — Need help with care
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
3. Has your pain interfered with your traveling?
   Travel anywhere I like — Only travel to see doctors
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
4. Has your pain affected your ability to sit or stand?
   No problems — Can not sit/stand at all
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
5. Has your pain affected your ability to lift overhead, grasp objects, or reach for things?
   No problem — Can not do at all
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
6. Has your pain affected your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — Can not do at all
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
7. Has your pain affected your ability to walk or run?
   No problems — Can not walk/run at all
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
8. Has your income declined since your pain began?
   No decline — Lost all income
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
9. Do you take pain medication every day to control your pain?
   No medication needed — On pain medication throughout day
   0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
10. Has your pain force you to see doctors much more often than before your pain began?
    Never see doctors — See doctors weekly
    0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
11. Has your pain interfered with your ability to see the people who are important to you?
    No problem — Never see them
    0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
12. Has your pain interfered with recreational activities and hobbies that are important to you?
    No interference — Total interference
    0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
13. Have you needed the help of family and friends to complete everyday tasks(at home and at work)because of pain?
    Never need help — Need help all the time
    0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
14. Have you felt more depressed, tense, or anxious than before your pain began?
    No depression/tension — Severe depression/tension
    0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
15. Are there emotional problems caused by your pain that interfere with family, social or work related activities?
    No problems — Severe problems
    0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Patient Signature: _____

Fakhoury Medical and Chiropractic Center

1009 SW 16th Lane Ocala, Fl 34471 (352) 351-3413 Fax (352) 629-6667

PIP- ASSIGNMENT OF BENEFITS

Name of Insured:_____
Date of Accident:_____
Name of Insurer:_____
PIP Policy Number:_____ **Claim Number**_____

The insured assigns all of the rights and benefits of any applicable personal injury protection (PIP), Medical Payments, or other coverage provided by any insurance policy issued pursuant to Fla Statutes 627.730-627.7405, to
Fakhoury Medical and Chiropractic Center for services and supplies provided related to personal injuries suffered in an automobile accident.

I understand that I am responsible for any co-payments or deductibles not covered by the applicable personal injury protection (PIP), Medical payments, or other insurance coverage.

This assignment includes, but is not limited to: All rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received. All rights to take legal or other action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefits due; and All rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and costs, for any legal or other action taken by Fakhoury Medical and Chiropractic Center as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy.
I agree that Fakhoury Medical and Chiropractic Center may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries.

I may be given a copy of this assignment to retain for my records if requested; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

Patient Name: _____ Date Signed:_____

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

I, the above named insured, hereby authorize and direct the above named insurer to send to Fakhoury Medical and Chiropractic Center, 1009 SW 16th Lane., Ocala, Fl 34471 (352) 351-3413 FAX (352) 629-6667, an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

Signature of Insured_____ Date Signed:_____

Fakhoury Medical & Chiropractic Center PLLC
1009 S.W. 16th Lane
Ocala, Florida 34471
352-351-3413 fax 352-629-6667

Fakhoury Medical and Chiropractic Center

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility/entity listed above.

The information you may release subject to this signed release form is as follows:

Complete Records History & Physical Progress Notes
Care Plan Lab Reports Radiology Reports
Other_____

Release these records from:

Name: _____

Address _____

City_____State_____Zip_____

Telephone #_____Fax #_____

To Be: Faxed to (352) 629-6667 Mailed

Comments:

Please fax to our office manually. Pt is here now. Thank you!

_____

_____

Patient Information:

_____
Print Patient's Name

_____
Signature of Patient

_____
Patient's Date of Birth

_____
Date of request

1009 SW 16th Lane, Ocala, FL 34471
Phone (352) 351-3413 Fax (352) 629-6667