Fakhoury Medical & Chiropractic Center: Medical Department

Today's Date: _____ **Account #:** _____

Patient Name: _____ **Nickname:** _____

Date of Birth: _____ Age: _____ SS#: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Work #: _____

E-mail: _____

Emergency Contact (Name/Phone #): _____

Marital Status: ☐ married, spouse's name: _____ ☐ single ☐ divorced ☐ widowed

Is there any chance you could be *pregnant*? ☐ NO ☐ YES, _____

Date of your last menstrual period (LMP): _____

Are you currently *breastfeeding*? ☐ NO ☐ YES, _____

Employer: _____ **Occupation:** _____

Full or part-time? _____ **Full or light-duty?** _____ **Job Duties:** _____

Have you missed any work? ☐no ☐yes, _____

Do you have a primary care provider (PCP)? ☐ no ☐ yes: name/location _____

Do you have a PHARMACY that you use? ☐ no ☐ yes: name/location _____

What caused your symptoms? ☐ motor vehicle accident ☐ fall ☐ sporting injury ☐ other:_____

When did your problems start or date of accident? (weeks, months, years, specific date): _____

Were you treated at the Emergency Room or Urgent Care?

☐ no ☐ yes, location: _____ dates: _____

Have you had any of the following tests? when/where:

EMG (nerve study) _____ MRI _____ CT Scan _____

Bone Scan _____ X-Ray _____ Ultrasound _____

If you have had any of the following procedures or therapies, please list when/where:

Chiropractic: _____ Physical Therapy: _____

Joint Injections: _____ Epidural Steroid Injections: _____

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. I 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 to 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.

Printed Name:_____

Signature: _____ **Date:**_____

Fakhoury Medical & Chiropractic Center: Medical Department

New Patient Health Evaluation

1. What are your **main problems or complaints?**
   1._____ 2._____ 3._____
   4._____ 5._____ 6._____

2. How would you **describe your pain?** Check all that apply: ☐ achy ☐ dull ☐ sharp ☐ burning ☐ throbbing ☐ numbness

3. Over the past few days/weeks, is your pain: ☐ improving ☐ worsening ☐ not getting any better ☐ the same

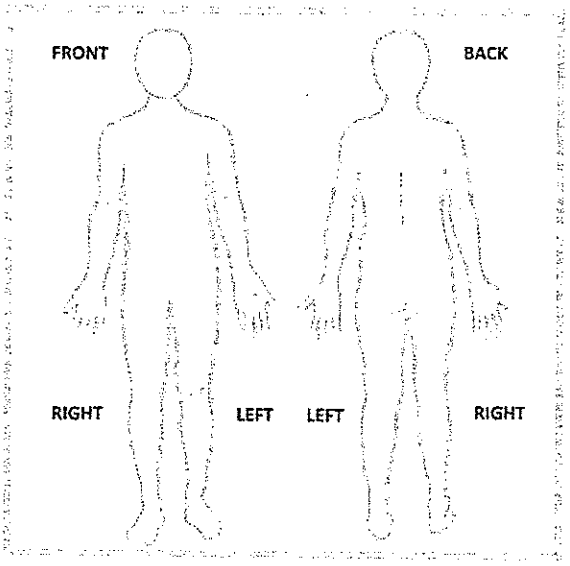
4. What **worsens** or **aggravates** the pain? Check all that apply.
   ☐ standing ☐ sitting ☐ lying down ☐ walking ☐ twisting ☐ driving ☐ leaning forward
   ☐ heat ☐ cold ☐ coughing ☐ sneezing ☐ reaching ☐ other: _____

5. What **reduces** or **alleviates** the pain? Check all that apply.
   ☐ standing ☐ sitting ☐ lying down ☐ walking ☐ twisting ☐ driving ☐ leaning forward
   ☐ heat ☐ cold ☐ coughing ☐ sneezing ☐ reaching ☐ other: _____

6. Has this affected your **sleep**? ☐ no ☐ yes, only getting _____ hours of sleep

7. Do you feel rested upon waking up? ☐ no ☐ yes

MARK AN 'X' ON THE BODY BELOW WHERE YOU FEEL PAIN



8. What **medications** are you taking including prescription and over-the-counter medications? List below.
   *Attach list when needed.

Current Medication Name: Prescription & Over-the-Counter	Dose: (mg)	Frequency: (once, twice, or three times daily)	This Medication is For: (pain, blood pressure, blood sugar, cholesterol, etc.)

Fakhoury Medical & Chiropractic Center: Medical Department

9. Do you have any **ALLERGIES**? _____

10. What is **your past / current medical history**? Check all that apply.

☐ asthma	☐ seizures	☐ bladder disorder	☐ thyroid	☐ bipolar disease
☐ bronchitis	☐ heart disease	☐ bowel disorder	☐ ulcers	☐ depression
☐ emphysema	☐ high blood pressure	☐ liver disease	☐ acid reflux	☐ rheumatism
☐ tuberculosis	☐ stroke	☐ kidney disease	☐ polio	☐ mental illness
☐ lung disease	☐ diabetes	☐ cancer: _____	☐ other: _____	

11. What activities have you had **difficulties performing** since your injury or accident? Check all that apply.

☐ bathing	☐ climbing stairs	☐ shopping	☐ yard work	☐ exercising
☐ dressing	☐ sweeping / mopping	☐ cooking	☐ driving	☐ managing funds
☐ showering	☐ washing dishes	☐ eating	☐ homework	☐ engaging with family
☐ brushing teeth	☐ laundry	☐ sleeping	☐ getting in / out of bed	
☐ brushing hair	☐ sexual activity	☐ relationships	☐ walking to bathroom	
☐ caring for children	☐ working: _____		☐ other: _____	

12. What is **your past surgical history**?

Surgery: (Examples: appendix / gallbladder removal, tonsillectomy, hernia repair, c-section, hysterectomy, spinal fusion, etc.)	**Date of Surgery:**

13. Does your **family history include**:

☐ genetic disease	☐ heart disease	☐ neurological disease	☐ stroke
☐ muscle disease	☐ diabetes	☐ alcoholism or illegal substance misuse	
☐ other: _____			

14. Do you have **any children**? ☐ no ☐ yes

15. Do you have any **hobbies or activities** that require a moderate level of physical activity?

Please list: (examples: golf, sports, gym, carpentry, etc.)_____

16. Do you **smoke**? ☐ no ☐ yes, _____ packs per day

17. Do you drink **alcohol**? ☐ no ☐ yes: _____ drinks per week

18. Do you use/take **drugs**? ☐ no ☐ yes: detail, _____

19. Do you drink **caffeine**? ☐ no ☐ yes: _____ cups per day

20. Do you **exercise**? ☐ no ☐ yes: _____ times per week

21. Have you had any of the **following symptoms within the past month?** Check all that apply.

HEENT:
- ☐ double vision
- ☐ blurred vision
- ☐ recent changes in vision
- ☐ ringing in the ears
- ☐ recent changes in hearing
- ☐ ear drainage
- ☐ dizziness
- ☐ headaches (mild / severe)
- ☐ severe recurrent nosebleed
- ☐ difficulty swallowing

CARDIOPULMONARY:
- ☐ dull chest pain
- ☐ chest pressure / tightness
- ☐ chest palpitations (fluttering)
- ☐ shortness of breath at rest
- ☐ shortness of breath with exertion
- ☐ shortness of breath when lying flat
- ☐ cough
- ☐ coughing up (blood / mucus)
- ☐ wheezing
- ☐ swelling feet
- ☐ severe night sweats

GASTROINTESTINAL:
- ☐ abdominal pain
- ☐ nausea / vomiting
- ☐ vomiting blood
- ☐ black & tarry stool
- ☐ bloody stools
- ☐ clay-colored stools
- ☐ difficulty holding bowel movements
- ☐ dramatic change in bowel habits
- ☐ jaundice (yellowing of skin, eyes)
- ☐ diarrhea
- ☐ constipation

GENITOURINARY:
- ☐ burning on urination
- ☐ blood in urine
- ☐ changes in urinary habits
- ☐ difficulty holding urine
- ☐ penile or vaginal discharge
- ☐ penile or vaginal bleeding
- ☐ genital sores

CONSTITUTIONAL:
- ☐ fever
- ☐ chills
- ☐ night sweats
- ☐ loss of appetite
- ☐ unintentional weight loss

SKIN:
- ☐ loss of hair
- ☐ discoloration to skin
- ☐ dry sores: _____location
- ☐ itchiness
- ☐ rashes
- ☐ bruising: _____location
- ☐ wounds: _____location

MENTAL HEALTH:
- ☐ anxiety
- ☐ depression
- ☐ frequent crying
- ☐ recent memory changes / loss
- ☐ aggression
- ☐ recent memory changes / loss
- ☐ restlessness at night

MUSCULOSKELETAL:
- ☐ joint pain
- ☐ joint swelling
- ☐ grinding of joints
- ☐ locking of joints
- ☐ neck pain
- ☐ back pain

CNS:
- ☐ paralysis in arms or legs
- ☐ numbness in arms or legs
- ☐ loss of consciousness
- ☐ seizures / new onset seizures
- ☐ jerking
- ☐ poor coordination
- ☐ changes in balance

ENDOCRINE:
- ☐ increase thirst
- ☐ excessive sweating
- ☐ excessive urination
- ☐ excessive drinking
- ☐ hot / cold intolerance

Signature of Patient: _____

Account # _____

Fakhoury Medical and Chiropractic Center

-Integrating Chiropractic, Physical Medicine and Rehabilitation-

MEDICAL RECORDS RELEASE/REQUEST 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. Patient 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 Ln. Ocala, FL 34471
Phone: (352) 351-3413 Fax: (352) 629-6667

Fakhoury Medical and Chiropractic Center

-Integrating Chiropractic, Physical Medicine and Rehabilitation-

HEALTH INSURANCE- ASSIGNMENT OF BENEFITS

The insured assigns all of the rights and benefits of any applicable Medical Payments, or other coverage provided by any insurance policy issued, to Fakhoury Medical and Chiropractic Center for services and supplies provided.

I understand that I am responsible for any co-payments or deductibles not covered by my Health 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 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:_____

Signature of Insured_____ Date Signed:_____

Fakhoury Medical & Chiropractic Center
1009 S.W. 16th Lane, Ocala, FL 34471
Phone: 352-351-3413 Fax: 352-629-6667

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ *Relationship:* _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):

_____

_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

☐ All past, present, and future periods, OR

☐ Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

SIGNATURE of the Individual Giving this Authorization Date

_____ _____

PRINT NAME of the Individual Giving this Authorization Date of birth

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

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 Center 1009 SW 16th Lane Ocala FL 34471, in order to carry out treatment, payment, 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 or 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 the patients 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 the 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 the patient (or an authorized representative) signs this Consent Form and then revokes said 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 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.

_____ _____

Signature of Patient Date Signed

_____

Please Print Name

_____ _____

Signature of Witness Date