Community Chiropractic of Country Club, PLLC

3263 Layton Ave, Bronx, NY 10465 Tel: (718)829-9666 Fax: (718)829-9799

REGISTRATION

Patient _____ _____ Date _____
Last Name First Name

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Social Sec # _____ Driver License # _____

Address _____ Apt #_____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ Height _____ Weight _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Insured Name _____ _____
Last Name First Name

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Condition/ Illness Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other _____

Referred By _____

EMPLOYER	Company Name _____ Occupation _____ Address _____ City _____ State _____ Zip _____ Phone _____ ☐ Full time ☐ Part time
SPOUSE (PARENT)	_____ _____ Last Name First Name Birth date _____ Social Sec # _____ Employer Name _____ Occupation _____ Address _____ City _____ State _____ Zip _____
PATIENT INSURANCE INFORMATION	Insurance Information: ☐ Group Ins ☐ Auto Accident ☐ Worker's Compensation ☐ Medicare ☐ Personal Payment Please list any and all coinsurance and/or employee health care plan coverage you may have Insurance Company or Health Care Plan Name _____ Policy/Group # _____ ID # _____ Effective Date _____ Name of Insured _____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group # _____ ID # _____ Effective Date _____ Name of Insured _____

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REGISTRATION

MEDICAL & LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ YES ☐ NO Your Initials _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician _____ Person to contact in emergency (Name & Phone) _____ Attorney _____ Phone _____ Address _____ City _____ State _____ Zip _____
PATIENT AGREEMENT	LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Community Chiropractic of Country Club, PLLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ _____ Signature of Insured/ Guardian Print Name Date
PAYMENT	Method of payment for services rendered: ☐ Insurance ☐ Cash ☐ Check

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HEALTH HISTORY

List drugs you are now taking: _____

Do you have(check if yes): ☐ cancer ☐ VD ☐ diabetes ☐ TB

Surgery History: _____

List fractures/dislocations/concussions past and present: _____

_____

List previous accidents/injuries/major illnesses: _____

_____

Family physician: _____ Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of last physical exam: _____

Is it possible that you are pregnant? _____ Are you nursing: _____

Would you like a report of your progress sent to your family physician? _____

PREVIOUS TREATMENT FOR THIS CONDITION

Chiropractor _____ Medical Doctor _____ Other _____

Treating physician(s): _____

Results: _____

Have you been placed on disability? _____ Date: From _____ - _____

By whom: _____

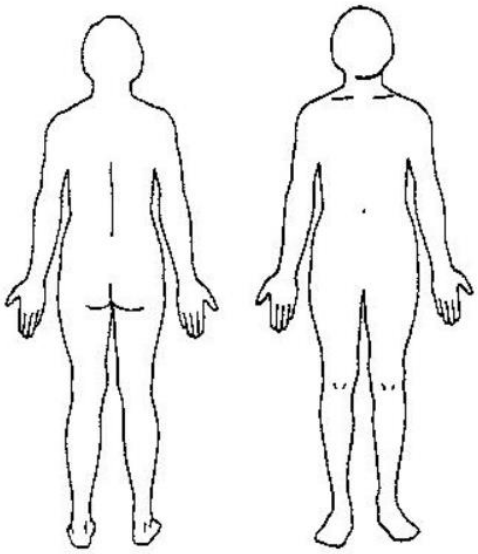
Have you ever suffered from: ☐ dizziness ☐ backaches ☐ heart trouble ☐ neurological

☐ digestive disorders ☐ arthritis ☐ headaches ☐ neck pain ☐ hormonal trouble

☐ Neuritis ☐ asthma ☐ diabetes ☐ nervousness ☐ sinus trouble

☐ Cardiovascular problems ☐ psychiatric history ☐ respiratory trouble

Please mark your area(s) of pain on the figures below:



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What is your major complaint:	Doctor's Comments:
_____ _____ How & when did this latest complaint happen: _____ _____ _____ Does anything relieve the problem? _____ _____ Does anything make the problem worse? _____ _____ What does the problem feel like? (Please describe) _____ _____ Does the pain move in your body? _____ _____ On a scale of 1-10 (1=least, 10=worst), rate the problem: _____ Does the problem affect your ability to do anything you want/need to do? Please be specific. (Ex: activities of daily living, grooming, bathroom activities, work, driving, raising children, etc.) _____ _____ _____ _____	Prior Chiro/Response to care: Meds: Hosp: Childbirth? Trauma: Health Prob: ETOH Smoker Y / N Fam Hx Occupation

Patient's Signature _____ Date: _____

Guardian's Signature _____ Date: _____

Community Chiropractic of Country Club, PLLC

NECK INDEX

Patient Name _____ Date _____

	Pain Intensity		***Personal Care***
0	I have no pain at the moment.	0	I can look after myself normally without causing extra pain.
1	The pain is very mild at the moment.	1	I can look after myself normally but it causes extra pain.
2	The pain comes and goes and is moderate.	2	It is painful to look after myself and I am slow and careful.
3	The pain is fairly severe at the moment.	3	I need some help but I manage most of my personal care.
4	The pain is very severe at the moment.	4	I need help every day in most aspects of self care.
5	The pain is the worst imaginable at the moment.	5	I do not get dressed; I wash with difficulty and stay in bed.
	Sleeping		***Lifting***
0	I have no trouble sleeping.	0	I can lift heavy weights without extra pain.
1	My sleep is slightly disturbed (less than 1 hour sleepless).	1	I can lift heavy weights but it causes extra pain.
2	My sleep is mildly disturbed (1-2 hours sleepless).	2	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned ex:on a table).
3	My sleep is moderately disturbed (2-3 hours sleepless).	3	Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4	My sleep is greatly disturbed (3-5 hours sleepless).	4	I can only light very light weights.
5	My sleep is completely disturbed (5-7 hours sleepless).	5	I can not lift or carry anything at all.
	Reading		***Driving***
0	I can read as much as I want with no neck pain.	0	I can drive my car without any neck pain.
1	I can read as much as I want with slight neck pain.	1	I can drive my car as long as I want with slight neck pain.
2	I can read as much as I want with moderate neck pain.	2	I can drive my car as long as I want with moderate neck pain.
3	I can not read as much as I want because of moderate neck pain.	3	I can not drive my car as long as I want because of moderate neck pain.
4	I can hardly read at all because of severe neck pain.	4	I can hardly drive at all because of severe neck pain.
5	I can not read at all because of neck pain.	5	I can not drive my car at all because of neck pain.
	Concentration		***Recreation***
0	I can concentrate fully when I want with no difficulty.	0	I am able to engage in all my recreation activities without neck pain.
1	I can concentrate fully when I want with slight difficulty.	1	I am able to engage in all my usual recreation activities with some neck pain.
2	I have a fair degree of difficulty concentrating when I want.	2	I am able to engage in most but not all my usual recreation activities because of neck pain.
3	I have a lot of difficulty concentrating when I want.	3	I am only able to engage in a few of my usual recreation activities because of neck pain.
4	I have a great deal of difficulty concentrating when I want.	4	I can hardly do any recreation activities because of neck pain.
5	I can not concentrate at all.	5	I can not do any recreation activities at all.
	Work		***Headaches***
0	I can do as much work as I want.	0	I have no headaches at all.
1	I can only do my usual work but no more.	1	I have slight headaches which come infrequently.
2	I can only do most of my usual work but no more.	2	I have moderate headaches which come infrequently.
3	I can not do my usual work.	3	I have moderate headaches which come frequently.
4	I can hardly do any work at all.	4	I have severe headaches which come frequently.
5	I can not do any work at all.	5	I have headaches almost all the time.

Neck Index Score

Community Chiropractic of Country Club, PLLC

BACK INDEX

Patient Name _____ Date _____

	Pain Intensity		***Personal Care***
0	The pain comes and goes and is very mild.	0	I do not have to change my way of washing or dressing in avoid pain.
1	The pain is mild and does not vary much.	1	I do not normally change my way of washing or dressing even though it causes some pain.
2	The pain comes and goes and is moderate.	2	Washing and dressing increases the pain but I manage not to change my way of doing it.
3	The pain is moderate and does not vary much.	3	Washing and dressing increases the pain and I find it change my way of doing it.
4	The pain comes and goes and is very severe.	4	Because of the pain I am unable to do some washing and without help.
5	The pain is very severe and does not vary much.	5	Because of the pain I am unable to do any washing and without help.
	Sleeping		***Lifting***
0	I get no pain in bed.	0	I can lift heavy weights without extra pain.
1	I get pain in bed but it does not prevent me from sleeping well.	1	I can lift heavy weights but it causes extra pain.
2	Because of pain my normal sleep is reduced by less than	2	Pain prevents me from lifting heavy weights off the floor.
3	Because of pain my normal sleep is reduced by less than	3	Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a
4	Because of pain my normal sleep is reduced by less than	4	Pain prevents me from lifting heavy weights off the floor, but I manage light to medium weights if they are conveniently positioned.
5	Pain prevents me from sleeping at all.	5	I can only lift very light weights.
	Sitting		***Traveling***
0	I can sit in any chair as long as I like.	0	I get no pain while traveling.
1	I can only sit in my favorite chair as long as I like.	1	I get some pain while traveling but none of my usual forms of make it worse.
2	Pain prevents me from sitting more than 1 hour.	2	I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
3	Pain prevents me from sitting more than ½ hour.	3	I get extra pain while traveling which causes me to seek forms of travel.
4	Pain prevents me from sitting more than 10 min.	4	Pain restricts all forms of travel except those done while lying
5	I avoid sitting because it increases pain immediately.	5	Pain restricts all forms of travel.
	Standing		***Social Life***
0	I can stand as long as I want without pain.	0	My social life is normal and gives me no extra pain.
1	I have some pain while standing but it doesn't increase with	1	My social life is normal but increases the degree of pain.
2	I can not stand for longer than 1 hour without increasing pain.	2	Pain has no significant affect on my social life apart from my more energetic interests (e.g., dancing, etc.).
3	I can not stand for longer than ½ hour without increasing	3	Pain has restricted my social life and I do not go out very often.
4	I can't stand for longer than 10 minutes without increasing	4	Pain has restricted my social life to my home.
5	I avoid standing because it increases pain immediately.	5	I have hardly any social life because of pain.
	Walking		***Changing Degree of Pain***
0	I have no pain while walking.	0	My pain is rapidly getting better.
1	I have some pain while walking but it doesn't increase with distance.	1	My pain fluctuates but overall is definitely getting better.
2	I can't walk more than 1 mile without increasing pain.	2	My pain seems to be getting better but improvement is slow.
3	I can't walk more than 1/2 mile without increasing pain.	3	My pain is neither getting better or worse.
4	I can't walk more than 1/4 mile without increasing pain.	4	My pain is gradually worsening.
5	I can't walk at all without increasing pain.	5	My pain is rapidly worsening.

Back Index Score

COMMUNITY CHIROPRACTIC OF COUNTRY CLUB, PLLC
JOSEPH J. PERRI, D.C.
www.BronxChiro.com

3263 Layton Avenue
Bronx, N.Y. 10465
Telephone: (718) 829-9666

Designation of Authorized Representative

I _____, do hereby designate Dr. Joseph Perri, Community Chiropractic of Country Club, PLLC to the full extent permissible under the Employee Retirement income Security Act of 1974 (”ERISA”) and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue other applicable remedies.

This authorization is valid and in effect unless I revoke it in writing.

_____
Patient’s Signature

_____
Patient’s Printed Name

_____
Date

Patient HIPAA Awareness

With my permission, Dr. Joseph Perri may use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Joseph Perri's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Joseph Perri reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Joseph Perri may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Joseph Perri may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cars and patient statements.

With my permission, the office of Dr. Perri may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Joseph Perri restrict how it uses or discloses my PHI to carry our TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Joseph Perri to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____

Print Legal Guardian's Name