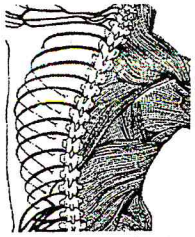

Welcome to Ottone Chiropractic Center

Patient Information

Name_____ Social Security #_____
Last Name First Name M.I.

Address _____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Sex ☐M ☐F Birth Date_____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by_____ Occupation_____

Business Address_____

Business Phone_____ Business Email_____

Notify in case of Emergency_____ Relation_____ Phone_____

Whom may we thank for referring you?_____

Insurance Information

Person Responsible for Account_____

Relationship to Patient_____ Birth Date_____ SS#_____

Address (if different from patient)_____ Phone_____

City_____ State_____ Zip_____

Employer_____ Occupation _____

Business Address_____ Business Phone _____

Insurance Company _____

ID# _____ Group # _____

Reason for Visit

Have you ever seen a Chiropractor? ☐Yes ☐No If yes, when and why?_____

Reason for this visit_____

Please describe your current pain and location _____

When did symptoms begin?_____ Have you had a similar condition in the past? Y / N

Pain is getting: Worse☐ Better☐ Same☐ Comes and goes ☐

Have you been treated by a medical physician for this condition?_____

If so, When and Where? _____

Activities that are difficult to perform: ☐Sitting ☐Walking ☐Standing ☐Other_____

Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Achy ☐Stiff ☐Burning ☐Tingling

☐ Numbness ☐Cramping ☐Tender ☐Other:_____

Pain is interfering with: ☐Work ☐Sleep ☐ Daily Routine ☐Recreation

Health History

Please list any medications (Including Pain Killers) you are currently taking:

_____

_____

_____

_____

Please list any medication allergies:

_____

_____

Smoking History: ☐ Never ☐ Current ☐ Former

Current Height:_____'_____" Current Weight:_____lbs. Last known blood pressure:_____

Is this a work related Injury? Y / N Date of injury at work: _____

Is this injury due to an auto accident? Y / N

Women: Are you Pregnant? ☐Yes ☐No If so, How far along?_____ Are you nursing? ☐Y ☐N

Please list any serious Medical conditions or surgeries you have had: _____

_____

_____

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in the my medical status, I will inform the chiropractic office.

I authorize my insurance company to pay the chiropractor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

OTTONE CHIROPRACTIC CENTER, PC
ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
&
DESIGNATION OF DISCLOSURE FORM

1. Acknowledgement of Privacy Practice Notice
I have received a copy of Ottone Chiropractic's Notice of Privacy Practices.

_____	_____	_____	_____
Patient's Name	Date of Birth	Signature	Date

2. I wish to be contacted in the following manner (check all that apply)

- ☐Home Phone
- ☐Written Communication
- ☐OK to leave message with detailed information
- ☐Leave message with call back number only
- ☐OK to call my work/office
- ☐OK to mail to my home address
- ☐OK to mail to my work/office
- ☐OK to fax to this number:_____
- ☐OK to email

3. Designation of Certain Relatives, Close Friends and Other Caregivers.

I agree that Ottone Chiropractic Center, PC may disclose certain of my health information to a family member, close personal friend or other caregiver as such persons may be involved in my health care or payment relating to my health care. In that case, Ottone Chiropractic Center, PC will disclose only information that is directly related to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare. I understand that I am not required to list anyone and that I may change this at any time.

Print Name/Relationship/DOB_____
Telephone #_____
Print Name/Relationship/DOB_____
Telephone #_____

I agree that Ottone Chiropractic Center may address me by my proper name and bill my insurance company electronically.

_____	_____
Signature of Patient/Parent/Guardian	Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Doctor/Hospital:_____

Address:_____

Date of Treatment:_____

I hereby authorize and request you to release all my records, X-Rays, Lab work and/or reports to:

Dr. Peter Ottone
Ottone Chiropractic Center
1140 Burnt Tavern Road, Unit 1C
Brick, NJ 08724
732-840-8400 fax 732-840-5970

_____

Signature of Patient Date

Right of Revocation: Under the provisions of HIPPAA, this patient has the right to revoke this authorization in writing. However, once this information has been used/released, the patient cannot revoke this authorization. Further, once this information has been released to a third party, said third party may in turn disclose this information, if the provisions of HIPPAA do not apply to them.

_____

Patient Name

_____

Address

_____

City State Zip

_____

Date of Birth

Confidential Notice

ATTENTION:
The requested facsimile contains PRIVELEDGED AND CONFIDENTIAL INFORMATION intended only for the use of the Addressee named above. If you are not the intended recipient, you are hereby notified that any dissemination of this fax in in violation of HIPPAA Regulations and is strictly prohibited.