Sylvester Chiropractic Centre

Welcome to our office!

Name:		Date:
Address:		
City/State/Zip:		Phone:
Age:	Birth Date:	Cell Phone #:
Social Security #:		Email Address:
Employed By:		Work Phone #:
Type of Work:		Student: ☐ Full Time ☐ Part Time
☐ Single ☐ Married ☐ Widowed ☐ Divorced		Spouse Name:

Insurance Number 1	
Name of Company:	
Group Name/No.:	
Policy Number:	
Name of Insured:	
Insured Birth Date:	
Insured SS#:	

Insurance Number 2	
Name of Company:	
Group Name/No.:	
Policy Number:	
Name of Insured:	
Insured Birth Date:	
Insured SS#:	

Other Insurance:		
Medical Doctor:		Last Visit:
In an emergency, whom should be notified:		Phone #:
Whom may we thank for referring you?		

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for any non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Signature _____ **Date** _____

I have read, and agree to the above statements.

Application for Care

Please print clearly

Name: _____ Birth Date _____ Date _____

Height _____ Weight _____ Sex _____ Case No. _____

Children *(list ages & sex)* _____

Describe major complaints & symptoms _____

_____

_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.
We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

Occasional | Frequent

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE & JOINT
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Pain between the shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, Numbness or Cramps
. . . in any of the following:
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

DATE OF LAST: (Approx.)
_____ Physical exam
_____ Blood test
_____ Chest X-Ray
_____ Spinal X-Ray
_____ Dental X-Ray
_____ Urine Test

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digestion
- ☐ ☐ Distention of abdomen
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear Noises
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Slow heart beat
- ☐ ☐ Swelling of ankles

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise Easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostrate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps of backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in Breast
- ☐ ☐ Menopausal Symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal Discharge

Pregnant ☐ yes ☐ no
Date of last period _____
Previous miscarriages ☐ yes ☐ no

HABITS
Alcohol: ☐ none, ☐ occasional, ☐ freq
Coffee: ☐ none, ☐ 1-3 cups, ☐ 3+ cups
Tobacco: ☐ never. ☐ current, ☐ former
Drugs: ☐ never, ☐ recreation, ☐ addict
Exercise: ☐ no, ☐ walk, ☐ swim, ☐ run ☐ daily, ☐ weekly

Please list any drugs now taken, allergies and past surgeries: _____

_____

_____

Have | Had

Check ☑ the following conditions you Have or Had—Circle items that are common to other family members.

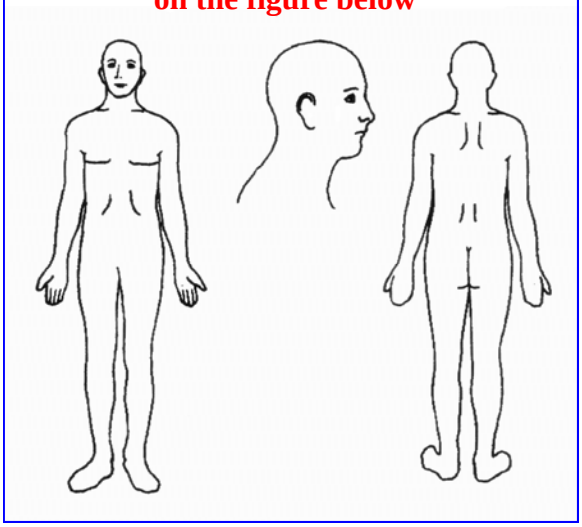
- ☐ ☐ Alcoholism
- ☐ ☐ Anemia
- ☐ ☐ Appendicitis
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Eczema
- ☐ ☐ Emphysema
- ☐ ☐ Goiter
- ☐ ☐ Gout
- ☐ ☐ Heart Disease
- ☐ ☐ Miscarriage
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Polio
- ☐ ☐ Rheumatic fever
- ☐ ☐ Stroke
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ Foot Problem

After reading and filling out the **Case History**, your signature will verify that all the information you have given us is accurate and that you have read the **Case History Questions** entirely.

Sign your name: _____ **Date** _____

Case History—Sylvester Chiropractic Centre

Please mark your area of pain on the figure below



Patient Comments: _____

Prior Chiro Care: ❒ Yes ❒ No

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Doctor's Comments—Do not write below this line

Tonsils: ❒ Present ❒ Removed

Surgery:

Assignment and Instructions for Direct Payment to Doctor Private and Group Accident and Health Insurance

RE:

Patient: _____

Employer: _____

Claim/Group #: _____

SS#/ID#: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Dr. Robert L. Sylvester
130 Kinderkamack Road, Suite 207
River Edge, NJ 07661

or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o 130 Kinderkamack Road, Suite 207
River Edge, NJ 07661

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

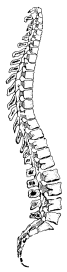
Dated at _____this _____day of _____

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder



Sylvester Chiropractic Centre

130 Kinderkamack Road
River Edge, NJ 07661
Phone: 201-488-2663
Fax: 201-488-0821
www.488BONE.com

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
a) A postcard mailed to me at the address provided by me; and
b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for *seven years*. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative* Relationship

Date Signed ____/____/____ Witness: _____

*Attorney-In-Fact, Guardian, Parent if a minor