Patient Account Number

_____

12595 SW 137 AVENUE STE 108
MIAMI, FL 33187
(305) 388-7577

Date

_____

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____ Nickname _____

Street Address _____ Apt. _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ E-mail Address _____ Age _____ Date of Birth _____

Appointment Reminders will be sent via text message 24 Hrs before appointment.

Marital Status
◯ Single ◯ Married ◯ Divorced ◯ Widowed

Sex
◯ Male ◯ Female

Please provide the **LAST 4 DIGITS** of your Social Security Number for insurance verification purposes
XXX-XX-_____

EMERGENCY CONTACT

Full Name _____ Relationship _____ Phone Number _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Martinez Chiropractic Center and any member of its staff to call, leave voice mail messages and\or e-mail messages and disclose Protected Health Information (PHI) pertaining to me, including but not limited to medical information, such as test results, procedures results, appointment reminders, or any other PHI related to my treatment to the following numbers:

Home: _____ Cell: _____ Work: _____ Fax: _____

Email: _____

I authorize Martinez Chiropractic Center and any member of its staff to disclose my (PHI), including test results to the following individuals, as well as allow them to make changes or ask questions regarding my appointments on my behalf:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

Patient Account Number

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

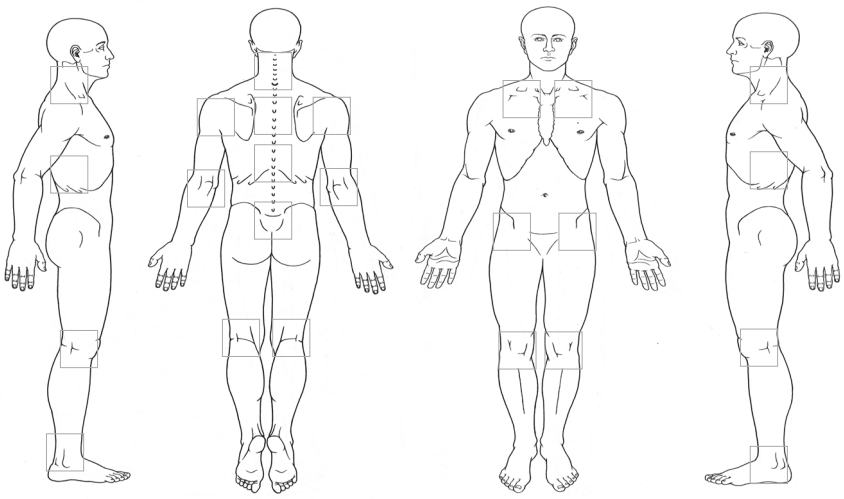
_____

Did your condition start due to an ☐ *Auto Accident* ☐ *Slip & Fall* ☐ *Workman's Comp.* **Date:** _____ ☐ **N/A**

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

None — *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ *No complaints* ① ② *Mild, forgotten with activity* ③ ④ *Moderate, interferes with activity* ⑤ ⑥ *Limiting, prevents full activity* ⑦ ⑧ *Intense, preoccupied with seeking relief* ⑨ ⑩ *Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

☐ Emergency Room ☐ Urgent Care ☐ None
☐ Other Chiropractor ☐ Medical Doctor

a. Where and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

10. Do you have an attorney representing you? ☐ Yes ☐ No

a. Attorney/Firm Name: _____
b. Phone Number: _____

11. What is your occupation?

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

12. Has your accident/injury prevented you from working?

☐ I am unable to work ☐ I am able to work with limitations ☐ I am able to work without limitations

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

Patient Account Number

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height ☐☐☐ (Feet / Inches) Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Inbalance
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	
☐	☐	High/Low Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Poor/Excessive Appetite
☐	☐	Abdominal Pain
☐	☐	Heartburn
☐	☐	Constipation/Diarrhea/Vomiting
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression/Anxiety/Panic Attacks
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

☐	☐	Birth Control Pills
☐	☐	Menstrual Irregularity/Cramps
☐	☐	Pregnancy
☐	☐	Last Menstual Cycle _____

Children ☐ None ☐ # of Children _____

Other Health Problems/Issues

☐ ☐ _____
☐ ☐ _____
☐ ☐ _____

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____ have received a copy of Martinez Chiropractic Center Notice of Patient Privacy Practices.

INFORMED CONSENT FORM

I, _____hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Martinez Chiropractic Center. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expecting to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

My signature certifies that I have read and agreed to what has been stated above.

_____ _____
Patient Signature Date

MARTINEZ CHIROPRACTIC
"Live Healthy, Be Happy"
Dr. Damian Martinez • Dr. Damaris Sabater • Dr. Thomas Krahn

Automobile Insurance Policy Information

Due to rules and regulations in the state of Florid, we must inform you that all automobile insurance carriers cover 80% of the allowed charges. It is the patient's responsibility to pay the remaining 20% co-insurance. If you have any health insurance or med-pay please notify our staff.

_____ _____ _____

Print Patient Name | Patient or Parent/Guardian Signature | Date

Insurance Certification

This is to certify that I, _____ have presented any and all information regarding my health and auto insurance plan(s).

The only auto insurance policy in effect is:

Name of Insurance Co._____

Insured's Name_____

Relationship with Insured_____

Policy #_____ Claim#_____

Date of Accident: _____

I, as the above captioned patient hereby attest that to the best of my knowledge, the insurance claims/policy information I have provided above is in fact the correct insurance information to which I am entitled to medical and/or PIP insurance coverage.

I understand that the medical provider is relying on this information in order to receive the appropriate coverage and qualify for payment for the medical services provided to me.

_____ _____

Patient or Parent/Guardian Signature | Print Patient's Name

_____

Date

This notice is sent in good faith so that I may utilize the benefits stated in my PIP policy for which I have paid premiums or am claiming benefits from.
If the claim or policy number listed above is not correct or your company is not able to match the insured you must notify the providers office within five business days or this information will be assumed correct and the providers office will not be prejudiced in its efforts in collecting for services provided.

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IRREVOCABLE ASSIGNMENT OF BENEFITS/POLICY RIGHTS

I, the undersigned patient hereby assign the rights and benefits of insurance of the applicable personal injury protections. Medical payments, and/or other insurance to **MARTINEZ CHIROPRACTIC CENTER** of services and/or supplies rendered for treatment of persona; injuries sustained in the accident of DOA _____ to the undersigned patient and covered by Personal Injury Protection (PIP Coverage of other insurance coverage under _____ in accordance with Florida Statute 627.736 (5). The undersigned agrees to pay any applicable deductible or co-payment not covered by the P.I.P or other insurance coverage. I have read the information herein and is true and to the best of my knowledge.

This assignment includes, but is not limited to all right to collect benefits directly from the insurance company for services that I have received; and all right to proceed against the insurance company obligated to provide benefits in any action including legal suit, if any reason the insurance company fails to make payments of benefits of which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with coping and mailing record to the insurer at the insurer's request and in accordance with Florida Statute 627.736 (6). This assignment also includes any right to recover attorney's fees and cost for such action brought by the provider as Patient's assignee. I agree that **MARTINEZ CHIROPRACTIC CENTER** may select any attorney he/she/it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily claim or case.

As part of this assignment of right and benefits, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and or necessity that the amount of benefits claimed by **MARTINEZ CHIROPRACTIC CENTER** is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so the he/she/it may exercise their legal rights. I understand that any person who knowingly files anything containing any false, incomplete or misleading information with the intent to injure defraud, or deceive any insurance company is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief.

_____ _____
PATIENT SIGNATURE DATE

_____
PATIENT'S PRINTED NAME

The undersigned on behalf of **MARTINEZ CHIROPRACTIC CENTER** hereby accepts assignment of the insurance right and benefits for the services rendered to _____
And to be paid directly to **MARTINEZ CHIROPRACTIC CENTER** under _____ Personal Injury Protection (P.I.P) or other insurance coverage with _____ and in accordance with Florida Statute 627.736 (5).

_____ TAX ID # 650348913
PROVIDER REPRESENTATIVE'S SIGNATURE

Irrevocable Lien

I do hereby authorize Martinez Chiropractic Center to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., in regards to the accident in which I was involved.

I hereby authorize my attorney to pay directly to said facility such sums as may be due and owing for medical services rendered both by reason of this accident and by reason of any other bill that are due to this facility and to withhold such sums from the settlement, judgment or verdict as may be necessary to adequately protect said doctor or facility. I hereby further give a lien on my case to said facility against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted for services rendered to me and that this agreement is made solely for said facility's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____	_____	_____
Print Patient Name	Patient or Parent/Guardian Signature	Date

The undersigned, being the attorney of records for the above patient, does hereby agree to observe all terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said facility above named.

_____	_____	_____
Law Firm	Attorney Signature	Date

Account Number: _____

Authorization to Release Medical Records

I, _____ authorize _____ to release my personal health information not already accepted by HIPPA or related statues, including x-ray films, diagnostic testing and any lab work.

(patient name) (doctor office)

_____	_____	_____	_____
Patient name (print)	Patient Signature	DOB	Date