



"Because it's about your health"

Dr. Archana Mehta
Chiropractic Physician

5537 Sheldon Rd. Suite T Tampa FL 33615
Tel: 813-885-5786

Dr. Gwen Pillow
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Dr. Ashley Sooklal
Chiropractic Physician

Fax: 813-886-0539

Chiropractic Case History / Patient Information

Date: _____
 Name: _____ Social Security #: _____ Home Phone: (____) _____
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail address: _____ Cell Phone: (____) _____
 Age: _____ Birth Date: ____/____/____ Marital Status: M S W D
 Occupation: _____ Employer: _____
 Employer's Address: _____ Office Phone: (____) _____
 Spouse: _____ Occupation: _____ Employer: _____
 How many children? _____ Names and Ages of Children: _____
 Name of nearest relative: _____ Address: _____ Phone: (____) _____
 How were you referred to our office? _____
 Family Medical Doctor: _____ Phone: (____) _____

When doctors work together it benefits you.

May we have your permission to update your medical doctor regarding your care at this office? Yes No

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____
 Date symptoms appeared or accident happened: _____
 Is this due to: Auto Work Other _____
 Have you ever had the same or a similar condition? Yes No
 If yes, when and describe: _____
 Days lost from work, if any: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from: (place a check by conditions that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Ulcers

Do you have a history of stroke or hypertension? _____
 Have you had any major illness, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates): _____
 Have you been treated for any health condition by a physician in the last year? Yes No
 If yes, describe: _____
 Do you have any allergies of any kind? Yes No If yes, describe: _____
 Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY:

Do you drink any alcoholic beverages? Yes No If so, how much per week? _____
 Do you use any tobacco products? Yes No Do you smoke? Yes No If so, how many packs per day? _____
 Do you take any vitamin supplements? Yes No If so, please list: _____
 Do you consume caffeine? Yes No If so, how much per day? _____
 Do you exercise? Yes No If yes, what is the frequency and type of exercise? _____

FAMILY HISTORY:

Father: Living Deceased Age if still living: _____ Cause of death & age at death if deceased: _____
 Mother: Living Deceased Age if still living: _____ Cause of death & age at death if deceased: _____

FAMILY DISEASES:

Check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother:

Tuberculosis	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Cancer	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Mental Illness	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B
Diabetes	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Asthma	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Heart Disease	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B
Stroke	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Kidney Disease	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Lung Disease	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B
Arthritis	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Liver Disease	<input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> B	Other	_____

Please check any and all insurance coverage that may be applicable in this case: Major Medical Auto Accident
Worker's Compensation Medicaid Medicare Medical Savings Account & Flex Plans Other
 Name of Primary Insurance Company _____
 Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I hereby instruct and direct _____ Insurance Company to pay directly to Chiropractic Naturally, the professional or medical expense benefits allowable and otherwise payable to me under my current Insurance Policy as payment toward the total charge for professional services rendered. There is a **DIRECT ASSIGNMENT OF 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 the current manner, any balance of said profession service charges over and above this insurance coverage. I also understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Signature: _____ Date: _____
 Print Name: _____
 Guardian's Signature Authorizing Care: _____ Date: _____
 Witness Signature: _____ Date: _____



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PAIN DRAWING

Name: _____

Date: _____

Date of Birth: _____

Examiner: _____

TELL US WHERE YOU HURT

Please read carefully:

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If you pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use appropriate symbol(s) listed below.

Ache >>>>>>>>>>>>

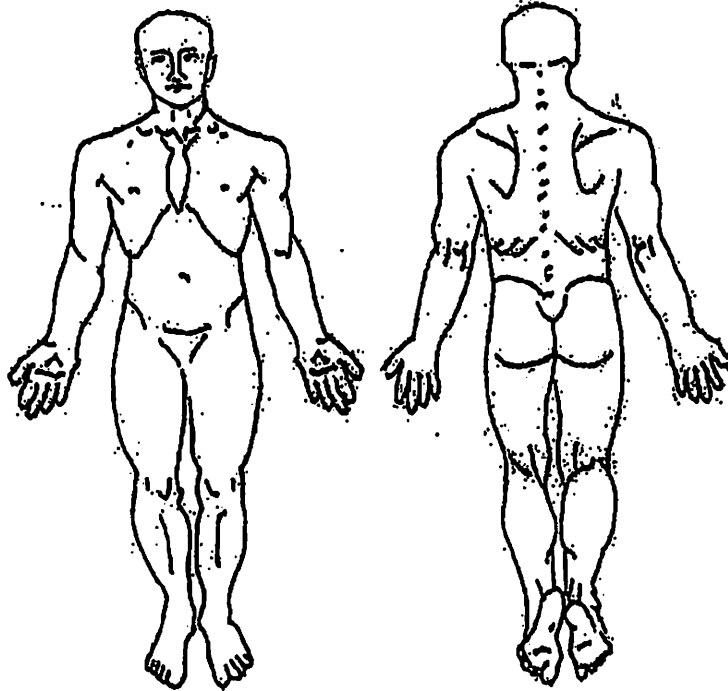
Numbness =====

Pins & Needles oooooooooo

Burning xxxxxxxxxxxx

Stabbing ////////////////

Throbbing ~~~~~





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Assignment and Instruction for Direct Payment for Private/Group Insurance

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

Chiropractic Naturally
Archana Mehta, DC
5537 Sheldon Rd
Suite T
Tampa, FL 33615

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

c/o Chiropractic Naturally
Archana Mehta, DC
5537 Sheldon Rd
Suite T
Tampa, FL 33615

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charge for professional services rendered. **THERE 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 the current manner, any balance of said professional service charges over and above this insurance policy.

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 on this _____ day of _____ 20__

Signature of Policyholder

Witness

Print name

Signature of Claimant, if other than policyholder



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INFORMED CONSENT FORM

I hereby request and consent to the performances of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by _____.
This consent is extended to other licensed chiropractic physicians, chiropractic assistants and 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, 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 expected 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.

Patient's name (please print)

Witness' name

Patient's signature

Witness' signature

Date

Date

Patient's representative

Patient's representative

Representative's relationship to patient
(If patient is a minor or if physically or mentally impaired)

Translated by

Doctor's name

Doctor's signature



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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.

I acknowledge that I have received your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize disclosure of my protected health information for the named individual(s) listed below:

Name

Relationship:

Name

Relationship:

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____



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Patient Name: _____

Health Care Authorization Form

The Patient Identified above authorizes Chiropractic Naturally to use and/or disclose protected health information in accordance with the following:

- . I give permission to Chiropractic Naturally to use my address, phone number, and clinical records to contact me with birthday cards, holiday related cards, recall cards, testimonials, appointment reminders, telephone calls and information about treatment alternatives or other health related information.
- . I give permission to Chiropractic Naturally to treat in an open door room. I am aware that the other persons in the office may over hear some of my protected health information during the course of the care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- . By signing this form you are giving Chiropractic Naturally permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Chiropractic Naturally. The written notice must contain the following: your name, date of birth, a clear statement of your intent to revoke the authorization, the date of your request and your signature.

This revocation is not effective until it is received by the Privacy Official.

This authorization is requested by Chiropractic Naturally for its own use/disclosure of PHI. (Minimum necessary standards apply.)

You have the right to sign this authorization. If you refuse to sign this authorization, Chiropractic Naturally will not refuse to provide treatment.

Patient Signature

Date