



Patient Application Form

Welcome to Oviedo Family Chiropractic. We are excited to have the opportunity to evaluate you to determine if you are a candidate for our type of care. We exist to help individuals and families reconnect to their God-given health potential by focusing on specific spinal corrective programs as well as educating the community on healthy living.

The following information will help us get to know your specific needs and determine what areas of your health need to be addressed.

We promise to do our best by providing you with a caring and friendly environment. We are proud to offer the most advanced chiropractic diagnostic tools to help locate the cause of your condition. We are excited to offer you the most current corrective chiropractic techniques that are designed for maximum comfort and effectiveness.

We ask that you fill out all the information as completely and accurately as possible. We also ask that you take an active role in your health by taking the time to allow us to not only get to know your needs, but also the time for us to thoroughly explain the results and optimal treatment options available to you and your family.

We do not accept all cases. If we feel we can help you, we will. If we feel we cannot, we will help you find someone who can. Again, we look forward to serving you. If you have any questions, please ask the front desk.

New Patient Application

Title: Mr. Mrs. Ms. Dr.

Last Name: _____ First Name: _____ MI: _____

Nick Name: _____ Date of Birth: ____/____/____ SS #: ____-____-____ Marital Status: _____

Home Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Home Phone: (____) _____

Cell Phone: (____) _____ E-Mail _____

Work Phone: (____) _____ May we contact you at work? Yes No

Employer Name: _____ Occupation: _____

Insurance Co: _____ Ins ID #: _____

Name of Insured: _____ Insured's Date of Birth: ____/____/____

Spouse Name: _____ Occupation: _____

Financially responsible person if other than patient:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Date of Birth: ____/____/____ SS#: ____-____-____ Relationship to Patient: _____

Employer Name: _____ Employer Phone: (____) _____

Emergency contact

Last Name: _____ First Name: _____

Contact Phone: (____) _____ Relation to patient: _____

Referral Source:

Who may we thank for referring you to our office? _____

Or, where did you hear about our office? _____

Chief complaint or reason for today's visit? _____
How long have you had this condition? _____ Date of Onset? _____
Have you had this condition before? _____ If yes, when? _____
Is the condition related to Work () Auto () Date of Accident: _____ Have you lost days from work? _____
What doctors have seen you for this condition? _____
What did they do? _____
When was your last visit to a chiropractor? _____ Were you helped? _____
What spinal correction programs were you given? _____
Did you follow them? _____ If not, why? _____ How did the post x-rays look? _____
On a scale of 1-10 (10 being of most value), how committed are you to improving your overall health and wellness? _____

Problem Area #1

The pain is located _____
The pain started _____ days ago _____ weeks ago _____ months ago _____ years ago
On a scale of 1-10 rate your pain No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain
How would you describe the pain dull, achy sharp, stabbing burning pins and needles
The pain is made *better* by _____
The pain is made *worse* by _____
The pain is (as far as timing is concerned: i:e: comes & goes, constant etc.) _____
 There is radiating pain, tingling, or numbness into _____

Additional Area #2

The pain is located _____
The pain started _____ days ago _____ weeks ago _____ months ago _____ years ago
On a scale of 1-10 rate your pain No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain
How would you describe the pain dull, achy sharp, stabbing burning pins and needles
The pain is made *better* by _____
The pain is made *worse* by _____
The pain is (as far as timing is concerned: i:e: comes & goes, constant etc.) _____
 There is radiating pain, tingling, or numbness into _____

Additional Area #3

The pain is located _____
The pain started _____ days ago _____ weeks ago _____ months ago _____ years ago
On a scale of 1-10 rate your pain No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain
How would you describe the pain dull, achy sharp, stabbing burning pins and needles
The pain is made *better* by _____
The pain is made *worse* by _____
The pain is (as far as timing is concerned: i:e: comes & goes, constant etc.) _____
 There is radiating pain, tingling, or numbness into _____

Is there any possibility of Pregnancy?

Yes No

Do you exercise? Yes No How often? _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much/week? _____

Any coffee/caffeine? Yes No How many cups/day? _____

Any supplements (i.e. vitamins, minerals, herbs)? _____

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called **Subluxations** (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted **POSTURE**. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called **Forward Head Syndrome** (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). **Please check any health conditions you may be experiencing, now or in the past.**

CERVICAL SPINE (NECK):

Postural distortions from **subluxations**, (causing **Forward Head Syndrome**), in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience...?

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay Fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Recurrent Colds/Flus |
| <input type="checkbox"/> Hearing disturbances/Ringing | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |
| <input type="checkbox"/> Changes in weight | <input type="checkbox"/> Inner Tension/Nervousness | <input type="checkbox"/> Disc Problems |

THORACIC SPINE (UPPER BACK):

Postural distortions from **subluxations** (resulting from **Forward Head Syndrome**), in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Palpitations/Murmurs | <input type="checkbox"/> Recurrent lung infections | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Tachycardia/Fast heart rate |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heart attacks/Angina | <input type="checkbox"/> Pain on deep breathing |

THORACIC SPINE (MID BACK):

Postural distortions from **subluxations** (resulting from **Forward Head Syndrome**), in the mid back will weaken the nerves in your ribs/chest and upper digestive tract and affect these parts of your body. Do you experience...?

- | | | |
|--|--|--|
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion/Heartburn |
| <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Tired/irritable after eating or when you haven't eaten in a while | |

LUMBAR SPINE (LOW BACK):

Postural distortions from **subluxations** (resulting from **Forward Head Syndrome**), in the low back will weaken the nerves in your legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- | | | |
|--|--|---|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Recurrent Bladder Infections |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (females) | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Disc problems |

Please list any health conditions not mentioned _____

Please list any medications/surgeries _____

Please list any traumas (falls, car accidents, etc.) _____

Patient Name: _____ **Signature:** _____ **Date:** _____

AUTHORIZATION TO RECEIVE MEDICAL RECORD INFORMATION

DR. ERIC JANOWITZ P.A. is hereby authorized to request the release of any medical records, laboratory test results, and radiographic & diagnostic imaging results, pertinent to the health care of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

DR. ERIC JANOWITZ P.A. is also authorized to release any medical records pertinent to the health care of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by said DR. ERIC JANOWITZ P.A.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Eric Janowitz and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Eric Janowitz, including those working at the clinic

I understand I will have the opportunity to discuss with the doctors of Oviedo Family Chiropractic, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

YOUR FINANCIAL RESPONSIBILITY

Payment is due when services are rendered unless prior arrangements (including insurance participation) have been made. The individual(s) above understands that a \$30 returned check fee will be charged should payments be made via check. The above individual(s) will also be responsible for any appropriate collection or attorney's fees which may accrue if it is necessary to engage collection services to pursue payment of any outstanding balance.

Patient Name: _____

Signature of patient or parent/legal guardian

Date

Witness of patient or guardian's signature

Date

**Oviedo Family Chiropractic
Patient Health Information Privacy Agreement
Consent for Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by **Oviedo Family Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Oviedo Family Chiropractic**. I understand that diagnosis or treatment of me by **Eric Janowitz, D.C.** or other doctors at Oviedo Family Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Oviedo Family Chiropractic** is not required to agree to the restrictions that I may request. However, if **Oviedo Family Chiropractic** agrees to a restriction that I request, the restriction is binding on **Oviedo Family Chiropractic** and **Eric Janowitz, D.C.** Unless Oviedo Family Chiropractic is notified otherwise, I consent to being contacted by Oviedo Family Chiropractic by telephone, mail, or other electronic means in order to confirm appointments, advise me of any shift closings, provide newsletters, or invite me to any special events. I also consent to having my picture taken in order for the doctors to help analyze my posture.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Eric Janowitz, D.C.** or **Oviedo Family Chiropractic** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member will speak with you about your condition or other matters in the closed private exam room.

Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness. If you object to the presence of your spouse or significant other at your report, please let us know immediately and we can refer you to another chiropractor.

In addition, we may disclose your PHI to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

I understand I have a right to review and a copy has been provided to me, upon my request, **Oviedo Family Chiropractic**'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Oviedo Family Chiropractic**. The Notice of Privacy Practices for **Oviedo Family Chiropractic** is provided at 1813 East Broadway, Oviedo, FL 32765.

This Notice of Privacy Practices also describes my rights and the **Oviedo Family Chiropractic**'s duties with respect to my protected health information.

Oviedo Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Description of Personal Representative's Authority