D'Oria Chiropractic
Dr. Lynn D'Oria, D.C.
18 Bridge Street Suite 1-B
Milford, NJ 08848-0276
908-995-8900

Consent to Use and Disclose Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as

- A basis for planning my care and treatment
- A means for communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a full copy of the office healthcare privacy policy is available and provides a more complete description of information uses and disclosures. I understand that I have a right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have a right to object to the use of my healthcare information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has lready taken action in reliance thereon.
I request the following restrictions to the use or disclosure of my health information:

____

____

____

I consent to the use and disclosure of my health information for treatment, payment and healthcare operations as described in the notice of information practices.
______Accepted _____Denied

____
Signature of patient or legal representative Date

____
Printed name of patient

Dr. Use Only:___________________________ Date:_________________
Pt. #:_____________________

PATIENT INFORMATION PT#________

Patient Name:______________________
Social security #:____________________
Drivers License Number:_____________
Which state?:______________________
Address:___________________________
____
E-mail:____________________________
Birthdate:_____________________
Male ( ) Female ( )
( ) Married ( ) Single ( ) Divorced
( ) Widowed ( ) Minor
( ) Partnered for _____ years
Employer/school_____________________
Employer address___________________
____
Employer phone #___________________
Spouse's name:_____________________
Spouse's employer:_________________
Whom may we thank for referring you?______________________________
How can we contact you? (select all that apply):
( ) home phone ( )work phone
( ) cell text ( ) email ( ) postal mail

INSURANCE INFORMATION

Who is responsible for this account?
____
SS# of insured ______________________
Birthdate of insured___________________
Relationship to patient ________________
Insurance Co. _______________________
Group #_____________________________
Policy # ____________________________

Assignment and release:

I certify that I, and/or my dependents, have insurance coverage with _______________ and assign directly to Dr. D'Oria all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am responsible for payment in full if services are deemed "not medically necessary" and therefore not covered by my insurance. I authorize the use for my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I agree to inform the doctor if my insurance policy changes over the course of care. Also, I verify that all the information on this form is accurate and correct.

X________________________ Date:_________

PHONE NUMBERS

Home _____________ Cell_____________
Best time to reach you________________
Emergency Contact:
Name:_________________________________
Number:_______________________________
Relationship:__________________________

ACCIDENT INFORMATION

Is this condition due to:
Employment? ( ) Yes ( ) No
Auto accident? ( ) Yes ( ) No
Other Accident? ( ) Yes ( ) No

If yes, STOP HERE and inform the doctor.

How would you describe your overall health history?____

Surgeries:____ Date:______________
____ Date:______________
____ Date:______________

Previous injury or trauma and outcome (include motor vehicle accidents, falls, dislocations, fractures) Date:
____ ____________
____ ____________
____ ____________
____ ____________

Have you been x-rayed for any reason? When and why? Outcome?________________________________
____

Patient Name: Date: Pt no.

Are you allergic to any medications?(circle) No Yes Please List:

Past Medical History Check all that apply | Current Medications

	Yes	No		Yes	No		Yes	No
Diabetes	[ ]	[ ]	Osteoporosis	[ ]	[ ]	Blood Clots	[ ]	[ ]
Chest Pain/Angina	[ ]	[ ]	Asthma/COPD	[ ]	[ ]	Peripheral Vascular Disease	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Stroke/CVA TIA	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Heart Disease	[ ]	[ ]	Seizures	[ ]	[ ]	Depression	[ ]	[ ]
Heart Attack	[ ]	[ ]	HIV/AIDS	[ ]	[ ]	Congestive Heart Failure	[ ]	[ ]
High Cholesterol	[ ]	[ ]	Hepatitis	[ ]	[ ]	Thyroid Disease	[ ]	[ ]
Pacemaker	[ ]	[ ]	Stomach Ulcer	[ ]	[ ]	Other (Please list below):		
Headaches	[ ]	[ ]	Liver Disease	[ ]	[ ]			
Kidney Stones	[ ]	[ ]	Heart Palpitations	[ ]	[ ]			
Kidney Disease	[ ]	[ ]	Arthritis	[ ]	[ ]			
Cancer	[ ]	[ ]	Heart Surgery:	[ ]	[ ]			

ROS	(-)	Please check all CURRENT positive findings
Constitutional		Weight loss [ ] Fevers [ ] Chills [ ] Poor appetite[ ] Fatigue[ ] Weight gain[ ] Insomnia[ ] night sweats[ ]
Eyes		Blurry vision[ ] eye pain[ ] eye discharge[ ] eye redness[ ] decrease in vision[ ] dry eyes[ ] double vision[ ]
ENT		Sore throat[ ] hoarseness[ ] ear pain[ ] hearing loss[ ] ear discharge[ ] nosebleeds[ ] tinnitus[ ] sinus problems[ ]
Cardiovascular		Chest pain[ ] palpitations[ ] rapid heart rate[ ] heart murmur[ ] poor circulation[ ] swelling of legs or feet[ ]
Respiratory		Short of breath[ ] chronic cough[ ] coughing up blood[ ] history of Tuberculosis[ ] excess sputum production[ ]
Gastrointestinal		Nausea[ ] vomiting[ ] diarrhea[ ] constipation[ ] blood in stool[ ] frequent heartburn[ ] trouble swallowing[ ]
Genitourinary		Increased urine frequency[ ] blood in urine[ ] incontinence [ ] painful urination [ ] urinary retention [ ] frequent UTI[ ]
Skin		Rash [ ] hives[ ] hair loss[ ] skin sores or ulcers[ ] itching[ ] skin thickening[ ] nail changes[ ] mole changes[ ]
Musculoskeletal		Joint pain[ ] muscle aches[ ] frequent leg cramps[ ] muscle weakness[ ] bone pain[ ] joint swelling[ ] back pain[ ]
Psychiatric		Anxiety[ ] Depression [ ] Alcohol or drug dependence [ ] Suicidal thoughts [ ] Panic attacks [ ] Use of anti-depressants[ ]
Endocrine		Goiter[ ] Heat intolerance [ ] Cold intolerance [ ] Increased thirst [ ] Change in skin pigment[ ] Excess sweating[ ]
Neurological		Seizures [ ] Tremors [ ] Migraines [ ] Numbness[ ] Dizziness/Vertigo[ ] Loss of balance [ ] Slurred speech[ ] Stroke[ ]
Hem/Lymphatic		Low blood count [ ] Easy bruising [ ] Swollen lymph nodes [ ] Transfusions [ ] Prolonged bleeding[ ] Blood clots[ ]
Allergic/Immun		Allergic reactions [ ] Hay fever [ ] Frequent infections [ ] Hepatitis[ ] HIV positive[ ] Positive tuberculin skin test (PPD) [ ]

Have you spoken to another doctor about any of these issues? If so, diagnosis?____

Which doctor?(name)____

____

If not, why not?____

Pregnancy History: # of pregnancies_____ # of live births______ # of miscarriages_____ vaginal/C-section?________
are you pregnant now?______ If yes, due date?_____________

Social History: Marital Status ______________ Occupation (or most recent job held ___________________________________

Circle one: Non-Smoker (never smoked) Ex-Smoker Current Smoker How many packs per day? __________

Alcohol consumption: Never Occasional Frequent

Do you exercise regularly? Yes No If yes, how often?_________________________

Family History: (Please list any known medical problems)

Father: ____ Mother: ____

Siblings: ____

Your Children: ____

Additional information which may be important to your healthcare:

Signature of Patient: **Date:**

Signature of Reviewing Physician: **Date:**

Notes:

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc 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 further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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

Name of Patient:____

Signature of Patient:____

Name Printed of Guardian/Parental and Relationship to Patient:_________________________

Guardian/Parental Signature:____
Date:___________________

Doctor of Chiropractic Name:_Dr. Lynn D’Oria D.C.

Signature of Doctor of Chiropractic:____

Date:____________________ Patient number:_________________________