CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Name _____ Social Security #_____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age ____ Date of Birth _____ Marital Status: M S W D

Cell Number _____ **Cell Phone Carrier** _____ **Email Address** _____
At&t, T-Mobile, Verizon, Etc...

Work Number _____ Work Address _____

Occupation _____ Referred by _____ Spouse's Name _____

HEALTH INFORMATION: Have you had previous chiropractic care? Yes or No

What is your major complaint? _____

_____

Other Complaints:_____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Other ☐ Comes & goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other

How long has it been since you really felt good? _____

Other doctors who have treated this condition: _____

_____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

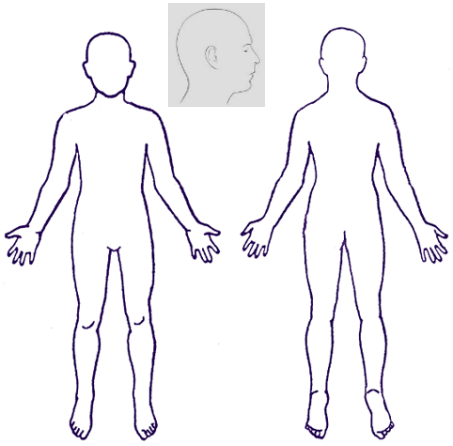
Have you been in an auto accident? ☐ Yes ☐ No If yes: Past year Past 5 years Over 5 years

Describe: _____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe: _____

Date of Last Physical Examination: _____



Have you ever suffered from:
(Check if applicable)

1. Dizziness _____
2. Backaches _____
3. Heart Troubles _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders ___
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

Vitals

Height: _____ Weight: _____

Please check one of the Following Below:

Never a Smoker____ Current Smoker____ Every day Smoker____ Former Smoker____ Sometimes___

Medication

Please list any **medications** and the **dosage** you are currently using:

_____

Allergies

Please List what your allergies that you may have: _____

Surgery

Have you had any surgeries? If so what were they? When? _____

Family History

Please list what kind of illnesses run in your family: _____

Social History

Smoking ___ Alcohol ____ Caffeine ____ Drug use ____ Exercise____ Other _____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? □ Yes □ No

Do you have Health Insurance? □ Yes □ No

Name of Company _____ **Policy #** _____

*** I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. ***

Patient Signature: _____ **Date:** _____

Guardian or Spouse's Signature: _____ Date: _____

Dr. George M. Rizos

Chiropractor

390 Merrick Avenue
East Meadow, NY 11554
(516) 489-2212

3089 Lawson Blvd
Oceanside, NY 11572
(516) 766-1717

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Private Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Private Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Relationship to patient (if other than self): _____

Date: _____

Dr. George M. Rizos

Chiropractor

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Dear _____
(Please print your name)

Effective 01/01/2015, due to the high demand for appointments with Dr. Rizos and the massage therapist our office will be charging a **$25.00** fee for the following:

- ***Failure to show up for your scheduled appointment.***
- ***Failure to give 24 hours' notice for a cancelled appointment.***
- ***Failure to give 24 hours' notice when rescheduling an appointment.***

We do understand that emergencies occur and will be taken into consideration. Please remember that the massage therapist's time is very valuable and when you do not keep a scheduled appointment you are delaying your own treatment and preventing another patient from receiving their treatment as well.

Thank you

The Staff

Patient Signature: _____ Date: _____