Miami Beach Natural Sports Medicine, Inc., dba

Miami Beach
Family & Sports Chiropractic Center

Today's Date _____
Date of Injury _____
File # _____

◆ **Confidential Patient Information** ◆

PLEASE PRINT:

Name _____ Social Security Number _____

Address _____ City _____ State ____ Zip _____

Age ____ Date of Birth ____ / ____ / ____ Sex M F Status: ○ Single ○ Married ○ Divorced ○ Widowed Number of Children ____

Home Phone _____ Bus.Phone _____ Cell Phone _____

Email _____ Instagram _____ Twitter _____

Occupation _____ Employer _____

Busines Address _____ City _____ State ____ Zip _____

Spouse/Parent Name _____ Date of Birth _____ Ph# _____

Emergency Contact _____ Phone _____

Address _____ City _____ State ____ Zip _____

What Hobbies/Sports Are You Active In ? _____

Purpose of Today's Visit: _____

Briefly State Your Main Complaint _____

Briefly Describe What Caused Your Symptoms _____

Briefly Describe How Your Symptoms Affect Your Daily Job, Household and/or Recreational Activities _____

ARE YOUR COMPLAINTS CAUSED FROM AN "ON THE JOB" INJURY OR FROM A PERSONAL INJURY SUCH AS A CAR ACCIDENT OR SLIP & FALL? IF YES, PLEASE TELL THE RECEPTIONIST IMMEDIATELY

Florida Law requires that you file any personal injury claims under your own insurance policy regardless of fault.

INSURANCE INFORMATION

Name of Insurance Co _____ Effective Date _____

Insurance Policy Number _____ Group Number _____

Are You The Primary Insured On This Insurance Policy? ○ Yes ○ No If NO, Who Is The Primary Insured?

○ Parent ○ Spouse ○ Someone Else (how are they related to you? _____

Primary Insured's Name _____ Date of Birth _____

Primary Insured's Address _____

City _____ State _____ Zip _____

Please present your insurance card(s) and photo I.D. to the receptionist

Authorizations & Releases

NAME: _____ **FILE #:** _____

☐ **Office Policy Regarding Payment For Services & Insurance Reimbursement:**

I understand and agree that health insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that the Miami Beach Family & Sports Chiropractic Center will prepare any necessary reports and forms to assist me in collecting from my insurance company, and that any amount authorized to be paid to Miami Beach Family & Sports Chiropractic Center, Inc., will be credited towards my account upon 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, including payment of any applicable insurance deductible and/or insurance co-payments. I also understand that if I suspend or terminate my care and treatment prior to the doctor releasing or discharging me from care, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date:____/____/____ Witness:_____

☐ **Authorization To Release Medical Information:**

I authorize the release of any medical information necessary to process my insurance claim(s). I also certify that all insurance information given to this healthcare provider is correct and complete.

Patient'sSignature:_____ Date:____/____/____ Witness:_____

☐ **Consent For Physician To Proceed With Examination & Treatment:**

Although extremely rare, there are risks of being treated with physical therapy, massage therapy, rehabilitation and chiropractic, including sprains, strains, fractures, herniation, burns, bruises, strokes and even death (1 in 5.85 million manipulations). I understand that if I am accepted as a patient by the physicians of the Miami Beach Family & Sports Chiropractic Center, I am authorizing them to proceed with any examination & treatment that may be necessary. Any risks regarding examination & treatment have been discussed and explained to my satisfaction and I understand the doctor feels the benefits outweigh the risks. I voluntarily consent to the rendering of care, including examinations, treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carryout the instructions of such physician(s).

Patient's Signature:_____ Date:____/____/____ Witness:_____

Parent or Guardian's
Signature Authorizing & Consenting To The Care Of A Minor:_____

☐ **Authorization To Release Healthcare/Medical Records:**

I, _____ hereby authorize any person to whom this authorization is presented, either in person, by mail, by fax or otherwise; to furnish the Miami Beach Family & Sports Chiropractic Center/Dr. Corey Narson/Dr. Todd Narson; ANY AND ALL MEDICAL RECORDS, MEDICAL REPORTS, X-RAYS OR OTHER DIAGNOSTIC TEST REPORTS & FILM concerning my present or past health condition/injury or general health status.

Patient's Signature:_____ Date:____/____/____Witness:_____

☐ **Limited Power Of Attorney To Endorse Checks:**

I agree that this office and any of its duly authorized agents and employees be given power of attorney to endorse/sign my name on any and all checks, drafts, money orders, unpaid insurance claims or affidavits, **which are payable to me for professional services rendered to me by Miami Beach Family & Sports Chiropractic Center/Dr. Corey Narson/Dr. Todd Narson**. The undersigned by these presents does thus give and grant this limited power of attorney to the above named office or doctor the full power and authority to do and perform the intents and purposes as the undersigned might or could do if personally present insofar as the endorsing and cashing of said checks are concerned. The undersigned does hereby ratify and confirm any and all actions taken by said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

Patient's Signature:_____ Date:____/____/____ Witness:_____

☐ **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient's Signature:_____ Date:____/____/____Witness:_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

REVIEW OF SYSTEMS **Name:** _____ **Date:** _____

General
☐ Unexplained weight loss ☐ Fever ☐ Trouble sleeping ☐ Weakness
☐ Unexplained weight gain ☐ Chills ☐ Recent cold or flu ☐ Fatigue ☐ NONE

Skin
☐ Rashes ☐ Itching ☐ Color changes ☐ Lumps ☐ Dryness ☐ Hair & nail changes ☐ NONE

Head
☐ Headache ☐ Head injury/trauma ☐ Bumps or areas of tenderness ☐ NONE

Eyes
☐ Visual problems ☐ Blurry vision ☐ Double vision ☐ Wear glasses/contacts ☐ Flashing lights
☐ Specks or spots in vision ☐ Pain ☐ Glaucoma ☐ Itching ☐ Redness ☐ NONE

Ears
☐ Decreased hearing ☐ Earache / Ear pain ☐ Ringling in ears (tinnitus) ☐ fluid discharge from ear(s) ☐ NONE

Nose
☐ Stuffiness ☐ Itching ☐ Nosebleeds ☐ fluid discharge ☐ Hay fever ☐ Sinus pain ☐ NONE

Throat
☐ Toothache ☐ Pain with swallowing ☐ Sore tongue ☐ Bleeding gums ☐ Non-healing sores
☐ Hoarseness ☐ Lump in throat ☐ Dry mouth ☐ NONE

Neck
☐ Lumps ☐ Pain ☐ Swollen glands ☐ Stiffness ☐ NONE

Breasts
Do you do Self Exams? ◯ Yes ◯ No ☐ Lumps ☐ Discharge Are you breast feeding? ◯ Yes ◯ No ☐ NONE

Respiratory
☐ Coughing (dry or wet, productive) ☐ Coughing up blood ☐ Shortness of breath ☐ Labored breathing
☐ Sputum/Color _____ ☐ Painful breathing ☐ Wheezing ☐ NONE

Cardiovascular
☐ Chest pain or discomfort ☐ Difficulty breathing when lying down ☐ Chest or shoulder/arm pain with physical activity
☐ Tightness in chest ☐ Shortness of breath with activity ☐ Sudden awakening from sleep w/shortness of breath
☐ Palpitations ☐ NONE

Gastrointestinal
☐ Difficulty swallowing ☐ Change in bowel habits ☐ Yellow eyes or skin ☐ Nausea ☐ Diarrhea
☐ Heartburn ☐ Rectal bleeding ☐ Gas or Bloating ☐ Abdominal pain after or during meal
☐ Change in appetite ☐ Constipation ☐ Abdominal pain prior to meal ☐ NONE

Urinary
☐ Urinate frequently ☐ Blood in urine ☐ Yellow eyes or skin ☐ Feel like urinating but can't or little
☐ Change in urinary strength ☐ Incontinence ☐ Burning with urination ☐ NONE

Genital

Male
Do you do regular self testicular exams? ◯ Yes ◯ No
☐ Sores ☐ Pain with sex ☐ STDs, if yes which _____ ☐ Erectile dysfunction
☐ Hernia ☐ Masses or pain ☐ Penile discharge ☐ NONE

Female
☐ Pain with sex ☐ STDs, if yes which _____ ☐ Vaginal discharge ☐ Vaginal dryness ☐ Hot flashes ☐ NONE

Vascular
☐ Calf pain when walking ☐ Leg cramping ☐ Varicose or spider veins ☐ NONE

Musculoskeletal
☐ Muscle or joint pain ☐ Back pain ☐ Neck pain ☐ Stiffness ☐ Redness of the joints ☐ Trauma ☐ Swelling of the joints ☐ NONE

Neurological
☐ Dizziness ☐ Weakness ☐ Tremors ☐ Fainting ☐ Numbness ☐ Headaches ☐ Seizures ☐ Tingling ☐ NONE

Hematologic
☐ Bruising easily ☐ Bleeding easily ☐ NONE

Endocrine
☐ Heat or cold intolerance ☐ Frequent urination ☐ Change in appetite ☐ Sweating ☐ Increase Thirst ☐ NONE

Psychiatric
☐ Nervousness ☐ Memory Loss ☐ Stress ☐ Depression ☐ Anxiety ☐ NONE

Workers' Compensation - "ON THE JOB" Injury

Date Injured _____ Last Date Worked _____ Has the injury been reported? ◯Yes ◯No *If No, Report It Immediately!*

Very briefly described how the accident / injury occurred _____

Have you ever injured this area before? ◯Yes ◯No Date(s) & cause of previous injury _____

Name of supervisor, foreman or manager _____ Phone # _____

Have you been contacted by an insurance company or company representative regarding this claim? ◯Yes ◯No

Who is your employer's Workers' Compensation insurance carrier? _____

Name & Address Insurance Carrier (if known) _____

Do you have an attorney representing you for this claim? ◯Yes ◯No Name of Attorney _____

Address of attorney _____ Phone # _____

"AUTOMOBILE ACCIDENT – CAR CRASH"

Date of Accident _____ Location _____ Direction Traveling: ◯N ◯S ◯E ◯W

Were you: ☐driver ☐front passenger ☐rear passenger ☐pedestrian, **(or)** I was riding a ☐bicycle ☐motor scooter ☐motorcycle

Were you struck from ☐behind ☐Rt. Side ☐Lt. Side ☐front , **Were you** ◯stopped –or- ◯moving

Did your car strike the other vehicle ◯Yes ◯No -or- Did the other vehicle strike yours ◯Yes ◯No

If the other vehicle struck yours, were you projected forward causing your vehicle to impact another vehicle? ◯Yes ◯No

Were you wearing a seatbelt at the time of impact ◯Yes ◯No

List the extent of your injuries as you know them _____

Did you receive emergency care or were evaluated by paramedics? ◯Yes ◯No **-AND-** Did you go to the hospital? ◯Yes ◯No

Name of Hospital _____ City/State _____ Admitted? ◯Yes ◯No

If admitted, how many days _____ Did you lose time from work? ◯Yes ◯No How much time lost _____

Have you had any similar accidents or injuries before? (if yes, please described) _____

Name of your automobile insurance company(required) _____ Policy # _____

Have you reported the accident to your insurance company (required) ◯Yes ◯No *If no, you must report accident immediately!*

Have you been contacted by an insurance company representative regarding this claim? ◯Yes ◯No, Rep. Name _____

Do you have an attorney that is advising you on this case? ◯Yes ◯No If yes,

Name of Attorney _____ Address _____ Phone _____

"OTHER ACCIDENTAL INJURY"

Date of Accident _____ Location _____

If not an "automobile collision" or an "on the job injury", please describe the circumstances:

Did you require hospitalization? ◯Yes ◯No Name of City & Hospital _____

Is any insurance company or attorney involved? ◯Yes ◯No

Insurance Company Name _____ Policy _____ Claim# _____

Insurance Company Address _____ Phone# _____

Name of Attorney _____ Address _____ Phone _____