Bergen Family Chiropractic Center
547 Main St. Hackensack, NJ 07601
Tel: 201-343-8282 Fax: 201-343-4669

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ____/____/____

Social Security Number: _____ Birth Date: ____/____/____ Age: ____ Gender: F M

CURRENT ADDRESS: _____

City _____ State _____ Zip _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Partnered

Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____ Phone: (____) _____

Who may we thank for referring you? _____

What brings you today? _____

MEDICAL HISTORY: Please check ALL that apply.

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

Approximately, when did your injury or condition occur? _____/_____/_____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

_____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: _____/_____/_____

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Date of last physical examination? _____

What surgery have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

Have you ever had any of the following diagnostic test? ☐X-ray ☐MRI scans ☐Bone scan ☐CT scan

Have you ever suffered from:

☐ AIDS/HIV	☐ Foot/Ankle Issues	☐ Pain in Arms/Hands
☐ Alcoholism	☐ Headaches/Migraines	☐ Pain in Legs/Feet
☐ Anxiety	☐ Heart Disease	☐ Ringing in Ears
☐ Arthritis	☐ Hip Issues	☐ Scapula Pain
☐ Asthma/Allergies	☐ Hernia	☐ Sciatica
☐ Backaches	☐ Jaw pain	☐ Scoliosis
☐ Cancer	☐ Loss of Balance	☐ Shortness of Breath
☐ Cardiovascular Issues	☐ Loss of smell	☐ Shoulder Pain
☐ Carpal Tunnel Syndrome	☐ Loss of strength Arm/Legs	☐ Sinus Trouble
☐ Circulation Issues	☐ Memory Loss	☐ Sleeping Problems
☐ Chest Pain/ Rib Pain	☐ Mental Health	☐ Stroke
☐ Constipation	☐ Mid Back Pain	☐ Tension
☐ Diabetes	☐ Nausea	☐ Tingling in Arms/Hands
☐ Digestive Issues	☐ Neck Stiffness/Pain	☐ Tingling in Legs/Feet
☐ Dizziness	☐ Nervousness	☐ TMJ Issues
☐ Elbow/Wrist/Hand Issues	☐ Numbness in Arms/Hands	☐ Urinary Issues
☐ Fainting	☐ Numbness in Legs/Feet	☐ Other _____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Recreational Drugs ☐ Yes ☐ No

CHILDREN & PREGNANCY:

How many children do you have? _____

Children's ages? _____

Children's health concerns? _____

Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Number of past pregnancies?_____

Health concerns regarding this pregnancy? _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS:

ALLERGIES(list)	MEDICATIONS(list)	SUPPLEMENTS(list)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure
Company:_____

Full Name of Policy Holder: _____

Policy Holder's Date of Birth ___/___/____

Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO

If yes, who is the employer? _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

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

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Informed Consent -- Chiropractic Care

[Please enter Rendering Provider(s) and Professional License(s)]

Patient's Name: _____

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name: _____

Patient's Signature: _____

Date of Signature: ____/____/____

Name of Parent / Guardian / Authorized Representative: _____

Signature: _____

Date of Signature: ____/____/____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: **Bergen Family Chiropractic Center**.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ____/____/____