

# CONFIDENTIAL PATIENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status: M S W D  
Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_ Occupation \_\_\_\_\_  
In case of emergency, who may we contact? \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## HEALTH INFORMATION

Have you had previous Chiropractic Care?  Yes  No Physical Therapy?  Yes  No

Main Complaint \_\_\_\_\_  
\_\_\_\_\_

Other Complaints \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had similar conditions in the past? \_\_\_\_\_

Does this condition affect your work? Yes  No

Does this condition affect your family or social life? Yes  No

What aggravates this condition? \_\_\_\_\_  
\_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_  
\_\_\_\_\_

Are you taking any medication? \_\_\_\_\_  
\_\_\_\_\_

What helps your symptoms? \_\_\_\_\_

Have you had any surgery, falls or accidents? Yes  No

When? \_\_\_\_\_ Please describe \_\_\_\_\_  
\_\_\_\_\_

Date of last physical examination \_\_\_\_\_

## INSURANCE INFORMATION

Is this condition due to Work related injury?  Yes  No Auto Accident?  Yes  No

If you answered yes to either of the above questions, please complete other side of form.

Are you covered by Medicare?  Yes  No Medicaid?  Yes  No

Do you have Major Medical Health Insurance? Yes  No

Insurance Carrier \_\_\_\_\_  
\_\_\_\_\_

## Do You Suffer From

	YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostrate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problem	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_  
Name of Insurance Company

and assign directly to Robert Gelman, D.C., PLLC and or Dr. \_\_\_\_\_  
all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

Complete only for:

**JOB INJURY INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Description of accident \_\_\_\_\_

Workman's Compensation Case # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Insurance Company Case # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Address and Phone \_\_\_\_\_

Hospitalized? \_\_\_\_\_ Name of Hospital \_\_\_\_\_ X-Rays Taken \_\_\_\_\_

Other Doctors seen \_\_\_\_\_

Are you working now? \_\_\_\_\_ Time lost from work \_\_\_\_\_

Do you have an attorney? Yes  No  Attorney's Name, Address, Phone #: \_\_\_\_\_

Complete only for:

**ACCIDENT INFORMATION:** Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Description of accident \_\_\_\_\_

If auto accident, were you  Driver  Passenger  Pedestrian

If auto collision, were you struck from  Behind  Right Side  Left Side  Front  Auto was Parked

Did your car strike the other(s) involved?  Yes  No

Or did the other car strike yours?  Yes  No  Undetermined

Do you have an attorney?  Yes  No

Attorney's Name, Address, Phone # \_\_\_\_\_

Did you require hospitalization:  Yes  No

Check symptoms you have noticed since accident:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Head Seems Too Heavy     | <input type="checkbox"/> Loss of Memory    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring         | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed      | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Buzzing in Ears   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Balance   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Loss of Smell     | <input type="checkbox"/> Other         |
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Depression               | <input type="checkbox"/> Loss of Taste     |  |

Symptoms other than above \_\_\_\_\_

**MEDICARE AUTHORIZATION**

I request that payment of authorized medicare benefits be made either of me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date

Robert Gelman, D.C., PLLC  
820 Hempstead Tpke.  
Franklin Square, N.Y. 11010  
(516) 307-1000

Informed Consent

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect Dr. Gelman to be able to anticipate or explain all risks and complications. I wish to rely on Dr. Gelman to exercise judgment during the course of the treatments which he feels at the time, based upon the facts known, is in my best interests.

Dr. Gelman has responded to all of my requests for information about the proposed treatment. I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment.

\_\_\_\_\_  
Print patient's name

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print parent/ guardian's name

\_\_\_\_\_  
Signature of parent/ guardian

\_\_\_\_\_  
Date

**Robert Gelman, D.C., PLLC**  
820 Hempstead Turnpike  
Franklin Square, N.Y. 11010

**PATIENT CONSENT  
FOR USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION  
TO CARRY OUT TREATMENT, PAYMENT  
AND HEALTHCARE OPERATIONS**

\_\_\_\_\_ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative  
(e.g., Attorney-in-Fact, Guardian, Parent if a minor):

\_\_\_\_\_  
Relationship

Robert Gelman, D.C., PLLC  
P.O. Box 591  
Hempstead Turnpike, NY 11010  
TIN# 26-1798597

DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

**Robert Gelman, D.C., PLLC PO Box 591 Franklin Square, NY 11010**

This is for the medical or professional expense benefits allowable, and otherwise payable to me under my current insurance policy towards the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

\*\*\*Patients Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_