Barczyk Spine & Joint

Confidential Patient Information

Patients Name:		tiai i aticiit imoi mation	Б.,
Address:	Acct #:		Date:
Address:	Patients Name:	Date of Birth:	M F
City: State: Zip: Work Phone:			
Are your present symptoms or condition related to, or the result of: []auto collision []work-related injury []other personal injury []none of the above DOI:			
Are your present symptoms or condition related to, or the result of: []auto collision []work-related injury [] other personal injury []none of the above DOI:	_		
[]auto collision []work-related injury [] other personal injury [] none of the above DOI:	Are your present symptoms or condition related to,	or the result of:	
Any SPINAL X-Rays / MRI's / CT's taken? Y N If so, Where? Marital Status: [] Married [] Single [] Divorced [] Widowe delight:			DOI:
Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Marital Status: [] Married [] Single [] Divorced [] Widowe Married [] Single [] Divorced [] Singl	Chief Complaint:		
The serious of the se	Any SPINAL X-Rays / MRI's / CT's taken? Y N	If so, Where?	
Person to contact in case of emergency (Name and Phone): Have you ever been under Chiropractic Care? Y N If so, Who? What operations have you had? When? When? When? Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N nat medications or drugs are you taking? (check those that apply): Pain Meds Muscle Relaxers nolesterol Meds Blood Pressure Meds Blood Thinner Birth Control Insulin her: Birth Control Insulin Birth Control Insulin Are considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the ever captioned, and hereby assign at clinic's request, and convey directly to Barczyk Spine & Joint all medical benefits and/or insurance reimbursement my, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless or applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby borize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and extellment information upon written request from such doctor and clinic and to the theory authorize the doctor to release all medical information in the respective over yot the above named doctor and clinic to the full extent permissible under the law of medical expenses incurred as any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any plotable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits claim submissions. Birth Control of my primary care physician. I authorize the use of this signature on all my insurance and/or employee health care	Occupation:	Marital Status: [] Mar	ried [] Single [] Divorced [] Widowe
When you ever been under Chiropractic Care? Y N If so, Who?	Height: Weight:	Family Physician:	
When you ever been under Chiropractic Care? Y N If so, Who?	Person to contact in case of emergency (Name and Phone): _		
When? Serious Illness: Men? When? When? When? When? When? When? When? When? Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N and medications or drugs are you taking? (check those that apply): Pain Meds Muscle Relaxers Muscle Relaxers Blood Pressure Meds Blood Thinner Birth Control Insulin Birth Control Insulin Mer: CGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the we captioned, and hereby assign at clinic's request, and convey directly to Barcynk Spine & Joint all medical benefits and/or insurance rembursement may, otherwise payable to me for services rendered from such doctor and clinic. I understand that I aminacially responsible for all charges regardless or applicable insurance or benefit payments. I hereby authorize the doctor to release a lumedical information execssary to process this claim. I hereby horize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable edies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not itsed to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. sreby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any blicable insurance policies and/or employee health care plan in my name but at such doctor and clinic			
Serious Illness:			
Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N nat medications or drugs are you taking? (check those that apply): Pain Meds	•	When?	
Have you ever had any Hip or Knee Replacements Y / N nat medications or drugs are you taking? (check those that apply): Pain Meds			
notesterol MedsBlood Pressure MedsBlood ThinnerBirth ControlInsulin_her: Blood Thinner	Do way have a mass maken 9 V / N	, , , , , , , , , , , , , , , , , , ,	N 1
considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the ove captioned, and hereby assign at clinic's request, and convey directly to Barczyk Spine & Joint all medical benefits and/or insurance reimbursement may, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby horize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable nedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not ited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. Proby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or ployee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any blicable insurance policies and/or employee health care benefits coverage under any above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable nedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic in any attempts by such doctor and clinic against su	Cholesterol MedsBlood Pressure Meds	Blood ThinnerBirth (ControlInsulin
ctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. Is assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have reasonable to the considered as valid as the original.	considering the amount of medical expenses to be incurred, I, the upove captioned, and hereby assign at clinic's request, and convey directly applicable insurance or benefit payments. I hereby authorize the otherize any plan administrator or fiduciary, insurer and my attorney settlement information upon written request from such doctor and emedies. I hereby authorize the doctor to release any and all medical mited to my primary care physician. I authorize the use of this signal hereby convey to the above named doctor and clinic to the full external ployee health care plan any claim, chose in action, or other right I implicable insurance policies and/or employee health care plan with release above named doctor and clinic and to the extent permissible under medies. Further, in response to any reasonable request for cooperat	ndersigned, have insurance and/or employ rectly to Barczyk Spine & Joint all medic r and clinic. I understand that I am financi doctor to release all medical information not to release to such doctor and clinic any archinic in order to claim such medical benefit information to other healthcare providers ture on all my insurance and/or employees at permissible under the law and under the may have to such insurance and/or employespect to medical expenses incurred as a retain the law to claim such medical benefits, in ion, I agree to cooperate with such doctor	vee health care benefits coverage with the cal benefits and/or insurance reimbursement ally responsible for all charges regardless of ecessary to process this claim. I hereby and all plan documents, insurance policy and fits, reimbursement or any applicable involved in my care including but not health benefits claim submissions. any applicable insurance policies and/or the health care benefits coverage under any esult of the medical services I received from a surance reimbursement and any applicable and clinic in any attempts by such doctor
	d clinic to pursue such claim, chose in action or right against my inactor and clinic against such insurers and/or employee health care pl	surers and/or employee health care plan, in an in my name but at such doctor and clinical in the such doctor and clinical in t	ncluding, if necessary, bring suit with such ic's expenses.

Date

UPDATED 12/21

Signature of Insured / Guardian