WELCOME

3 LOCATIONS TO SERVE YOU BETTER!

PINES WEST CHIROPRACTIC
18501 Pines Blvd., Suite 104
Miami, FL 33029

EAST SIDE CHIROPRACTIC
8228 Biscayne Blvd.
Miami, FL 33138

MARTINEZ CHIROPRACTIC
12595 S.W. 137 Ave., Ste 108
Miami, FL 33186

PATIENT INFORMATION

Patient: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Sex: ☐ M ☐ F Age: _____ DOB: _____
☐ Single ☐ Married ☐ Widowed ☐ Divorced
Patient SS No. _____ Occupation: _____
Employer _____ Employer Phone No. _____
Employer Address: _____
Spouse's Name: _____ Birthdate: _____
Patient SS No. _____ Occupation: _____
Spouse's Employer: _____
Primary Care Physician: _____ Phone Number: _____
Whom may we thank for referring you: _____

PHONES NUMBERS

Home: _____
Work: _____
Ext: _____
Best time to call _____
_____
Cell Phone: _____
Email: _____

IN CASE OF EMERGENCY

Name: _____
Relationship: _____
Home #: _____
Work: _____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. Name _____
Group or Card No. _____
Is Patient covered by additional insurance ☐ Yes ☐ No
Subscriber's Name _____
Birthdate _____ SS No. _____
Relationship to Patient _____
Insurance Co. Name _____
Insurance I.D. No. _____

ACCIDENT INFORMATION

Is condition due to an accident?
☐ Yes ☐ No Date _____

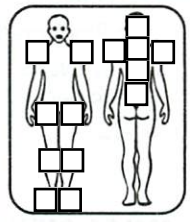
Type of Accident?
☐ Auto ☐ Work ☐ Home ☐ Other

Explain Other: _____

If yes, please tell our front office and fill out correct accident form in addition to this form.

PATIENT CONDITION

Reason for Visit: _____ Preventive health check up: ☐ Yes ☐ No
When did your symptoms appear? _____ Is condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown
Mark an x on the picture where you continue to have pain, numbness or tingling _____
Rate the severity of your pain on a scale of 1 (least pain to 10 (server pain) _____
Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning
☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How many days in the last week did you feel the pain? ☐ Is it constant or ☐ Occasional
Does it interfere with your ☐ Work ☐ Family Life ☐ Sleep ☐ Recreation ☐ Exercise
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Driving
Do you suffer from any other health conditions? _____



PAST HEALTH HISTORY

Please Check and Describe: _____
Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other _____
Car accidents, falls, injuries: _____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____
Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/ Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin
☐ Other _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However the questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD OR CURRENTLY HAVE:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ *Chemical Dependency*
- ☐ Alcoholism
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Asthma
- ☐ Aids/H.I.V.
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Weak Immune System
- ☐ Subluxations
- ☐ Pacemakers
- ☐ Multiple Sclerosis
- ☐ Psychiatric Care
- ☐ Hepatitis
- ☐ Hernia
- ☐ Carpal Tunnel Synd.
- ☐ Repetitive Strain Synd.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Hand/Wrist Pain
- ☐ Foot/Ankle Pain

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R CODE

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Venereal Disease
- ☐ Other Problems _____

_____

_____

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ *Numbness*
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

EENT CODE

- ☐ Vision Probers
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FAMILY HISTORY

The following members have the same or similar problems as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

FEMALES ONLY

When was your last menstrual cycle? _____ Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Computers
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level

What is most important in your Doctor/Patient relationship? _____

_____

What are your health goals? ☐ pain relief only ☐ correct my health problem

Signature _____

AUTO ACCIDENT FORM

ABOUT YOU

Please Fill Out Completely

Name:_____

Today's Date:_____/_____/_____

WHAT WE NEED

Please present us with a copy of the police/accident report and/or medical records, hospital and/or Doctor's reports, diagnostic tests results, ex: MRI, C.T. Scans, X-Rays, others.

Thank You.

ACCIDENT INFORMATION

Date & Time of Accident_____ a.m. p.m.

Were you the: ❑ driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle?_____

Name and addresses/phone no.'s of people in accident_____

_____

_____

Did the police come to the accident site? ❑ Yes ❑ No

Was a police report filed? ❑ Yes ❑ No

Were there any witnesses? ❑ Yes ❑ No

Were you wearing a seatbelt? ❑ Yes ❑ No

Was this vehicle equipped w/ airbags? ❑ Yes ❑ No

If yes, did they inflate? ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest?

❑ Above ❑ Below ❑ At base of skull

What did your vehicle impact? ❑ Another Vehicle ❑ Other

If other, explain:_____

Did any part of your body strike anything in the vehicle?

❑ Yes ❑ No If yes, explain:_____

Did your vehicle go off the road?_____

Make and model of the vehicle your were occupying?_____

_____

Name of the location/street on which you were traveling?_____

_____

In which direction were you headed? ❑ N ❑ S ❑ E ❑ W

What was the approx. speed of your vehicle?_____

Did the impact come from the : ❑ Rear ❑ Front ❑ Side

During the impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you: ❑ Aware ❑ surprised by the impact?

If accident vehicle made impact with another vehicle what was Make & Model/Year of the other vehicle

Direction other vehicle was headed? ❑ N ❑ S ❑ W ❑ E

Speed of the other vehicle?_____

Briefly describe accident:_____

_____

_____

_____

Have you reported your accident to your auto insurance company? ❑ Yes ❑ No

ACCIDENT INFORMATION (cont.)

Did Accident render you unconscious? ❑ Yes ❑ No

If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor?

❑ Yes ❑ No

When did you go?

❑ Just after accident ❑ Next day ❑ 2 days plus

How did you get there?

❑ Ambulance ❑ Private Transportation

Name of Hospital and/or Attending Doctor:_____

Was he/she a: ❑ Chiropractor ❑ M.D. ❑ Dentist

Describe any treatment you received:_____

_____

_____

Were X-rays taken? ❑ Yes ❑ No

Was medication prescribed? ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury?

❑ Yes ❑ No

AUTO INSURANCE

Type of Insurance:_____

Company Name:_____

Address:_____

Phone No:_____

Insured's Name:_____

Policy No:_____ Claim No:_____

Insured's SS No:_____ DOB:_____

Insured's Employer:_____

Agent's Name:_____

List all automobiles owned by you or any family member living with you at the time of the accident:_____

_____

_____

Have you retained an attorney? ❑ Yes ❑ No

Name of attorney?_____ Phone:_____

Address:_____

City_____ State_____ Zip Code_____

*Patient's Signature*_____ *Date*_____

MARTINEZ CHIROPRACTIC
"Live Healthy, Be Happy"
Dr. Damian Martinez • Dr. Damaris Sabater • Dr. Thomas Krahn

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Martinez Chiropractic Center and any member of its staff to call, leave voice mail messages and\e-mail messages and disclose Protected Health Information (PHI) pertaining to me, including but not limited to medical information, such as test results, procedures results, appointment reminders, or any other PHI related to my treatment to the following numbers:

O Home Number O Cell Phone Number

O Work Number O Email

Appointment Reminders:

OText Message
Cell Phone Company: _____

OEmail _____

ONo Reminder

All reminders are sent approximately 24 hours prior to your appointment.

I authorize Martinez Chiropractic Center and any member of its staff to fax my (PHI), including medical information needed for my treatment to the following fax number: _____.

I authorize Martinez Chiropractic Center and any member of its staff to disclose my (PHI), including test results to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____ have received a copy of Martinez Chiropractic Center Notice of Patient Privacy Practices.

INFORMED CONSENT FORM

I, _____hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Martinez Chiropractic Center. This consent is extended to other licensed chiropractic Physicians, Chiropractic assistants or licensed Massage Therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have had the opportunity to discuss, with the doctor of Chiropractic and/or other office personnel, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of Chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expecting to be able to anticipate and explain all the risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have had read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

My signature certifies that I have read and agreed to what has been stated above.

_____ _____

Patient Signature Date

Automobile Insurance Policy Information

Due to rules and regulations in the state of Florid, we must inform you that all automobile insurance carriers cover 80% of the allowed charges. It is the patient's responsibility to pay the remaining 20% co-insurance. If you have any health insurance or med-pay please notify our staff.

_____ _____ _____
Print Patient Name | Patient or Parent/Guardian Signature | Date

Insurance Certification

This is to certify that I, _____ have presented any and all information regarding my health insurance plan(s).

The only health insurance policy in effect is:

Name of Insurance Co._____

Insured's Name_____

Relationship with Insured_____

Policy #_____ Claim#_____

Date of Accident: _____

I, as the above captioned patient hereby attest that to the best of my knowledge, the insurance claims/policy information I have provided above is in fact the correct insurance information to which I am entitled to medical and/or PIP insurance coverage.

I understand that the medical provider is relying on this information in order to receive the appropriate coverage and qualify for payment for the medical services provided to me.

_____ _____
Patient or Parent/Guardian Signature | Print Patient's Name

_____
Date

This notice is sent in good faith so that I may utilize the benefits stated in my PIP policy for which I have paid premiums or am claiming benefits from.
If the claim or policy number listed above is not correct or your company is not able to match the insured you must notify the providers office within five business days or this information will be assumed correct and the providers office will not be prejudiced in its efforts in collecting for services provided.

MARTINEZ CHIROPRACTIC
"Live Healthy, Be Happy"
Dr. Damian Martinez • Dr. Damaris Sabater • Dr. Thomas Krahn

IRREVOCABLE ASSIGNMENT OF BENEFITS/POLICY RIGHTS

I, the undersigned patient hereby assign the rights and benefits of insurance of the applicable personal injury protections. Medical payments, and/or other insurance to **MARTINEZ CHIROPRACTIC CENTER** of services and/or supplies rendered for treatment of persona; injuries sustained in the accident of DOA _____ to the undersigned patient and covered by Personal Injury Protection (PIP Coverage of other insurance coverage under _____ in accordance with Florida Statute 627.736 (5). The undersigned agrees to pay any applicable deductible or co-payment not covered by the P.I.P or other insurance coverage. I have read the information herein and is true and to the best of my knowledge.

This assignment includes, but is not limited to all right to collect benefits directly from the insurance company for services that I have received; and all right to proceed against the insurance company obligated to provide benefits in any action including legal suit, if any reason the insurance company fails to make payments of benefits of which o am due. Specifically, this assignment includes the right to collect payment for the reasonable costs connected with coping and mailing record to the insurer at the insurer's request and in accordance with Florida Statute 627.736 (6). This assignment also includes any right to recover attorney's fees and cost for such action brought by the provider as Patient's assignee. I agree that **MARTINEZ CHIROPRACTIC CENTER** may select any attorney he/she/it wishes and understand and agree that the attorney selected by them may be different than the attorney handling my personal injury/bodily claim or case.

As part of this assignment of right and benefits, I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and or necessity that the amount of benefits claimed by **MARTINEZ CHIROPRACTIC CENTER** is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so the he/she/it may exercise their legal rights. I understand that any person who knowingly files anything containing any false, incomplete or misleading information with the intent to injure defraud, or deceive any insurance company is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief.

_____ _____

PATINET SIGNATURE DATE

_____

PATIENT'S PRINTED NAME

The undersigned on behalf of **MARTINEZ CHIROPRACTIC CENTER** hereby accepts assignment of the insurance right and benefits for the services rendered to _____
And to be paid directly to **MARTINEZ CHIROPRACTIC CENTER** under _____
Personal Injury Protection (P.I.P) or other insurance coverage with _____
and in accordance with Florida Statute 627.736 (5).

Irrevocable Lien

I do hereby authorize Martinez Chiropractic Center to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc., in regards to the accident in which I was involved.

I hereby authorize my attorney to pay directly to said facility such sums as may be due and owing for medical services rendered both by reason of this accident and by reason of any other bill that are due to this facility and to withhold such sums from the settlement, judgment or verdict as may be necessary to adequately protect said doctor or facility. I hereby further give a lien on my case to said facility against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted for services rendered to me and that this agreement is made solely for said facility's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____	_____	_____
Print Patient Name	Patient or Parent/Guardian Signature	Date

The undersigned, being the attorney of records for the above patient, does hereby agree to observe all terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said facility above named.

_____	_____	_____
Law Firm	Attorney Signature	Date

Patient Account #: _____