Platinum Health & Wellness

General Information

Patient Name:		Date:	
Sex: M / F	Date of Birth:		Age:
Address:	City:	State:	Zip code:
Cell Phone #:		May we contact you via text Message?: Y / N	
Employer:		Occupation:	
Have you been to a chiropractor before? Y / N		Marital Status: S / M / D / W	

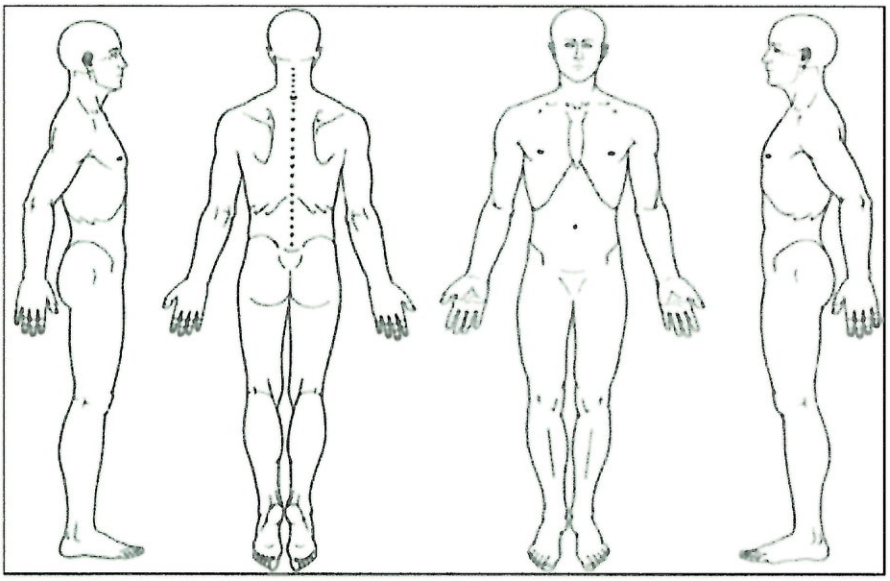
In Case of Emergency

Contact Name:	
Relationship:	Address:
Cell PHONE :	How did you hear about our office?

Main Problem

Reason for Today's Visit:			
How long have you had this problem:	YEARS	MONTHS	WEEKS
What makes it better or worse:		Rate the Pain : _____ (0 = nothing, 10 = worst imaginable)	

On the diagram below, please indicate where you are experiencing pain right now. Please use key to the right of the diagram to further explain what type of sensations you are experiencing in each area.



ARE YOU A: (PLEASE CIRCLE ONE) CURRENT SMOKER FORMER SMOKER NEVER SMOKED
DO YOU DRINK ALCOHOL? (PLEASE CIRCLE ONE) YES NO IF YES, HOW FREQUENTLY? SOCIALLY ONLY SEVERAL TIMES PER WEEK EVERYDAY
DO YOU OR HAVE YOU EVER USED RECREATIONAL DRUGS? (PLEASE CIRCLE ONE) YES NO
ARE YOU CURRENTLY PARTICIPATING IN SPORTS? (PLEASE CIRCLE ONE) YES NO IF YES, WHAT SPORT? GOLF TENNIS FOOTBALL SOCCER BASEBALL/SOFTBALL BASKETBALL OTHER

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ANEMIA	☐GOUT	☐OSTEOPOROSIS/OSTEOPENIA	☐CONCUSSION/HEAD INJURY
☐ARTHRITIS	☐HEART DISEASE/ATTACK	☐SEIZURES	☐LUNG DISEASE/COPD
☐AUTOIMMUNE DISEASE	☐HIGH BLOOD PRESSURE	☐STROKE	☐IRRITABLE BOWEL DISEASE
☐ASTHMA	☐KIDNEY DISEASE	☐SCOLIOSIS	☐MIGRAINE HEADACHES
☐CANCER	☐LIVER DISEASE/HEPATITIS	☐THYROID DISEASE	☐BLEEDING DISORDER
☐GLAUCOMA	☐ MENTAL ILLNESS/DEPRESSION	☐PREGNANCY	☐HIV/AIDS
☐DIABETES	☐OTHER:		

SURGERY	DATE	SURGERY	DATE
JOINT REPLACEMENT		HIP / KNEE / SHOULDER	
SPINE SURGERY		COSMETIC/PLASTIC SURGERY	
HERNIA REPAIR		OTHER: PLEASE LIST	
APPENDIX			
C-SECTION/HYSTERECTOMY/LAPAROTOMY			
HEART SURGERY/BYPASS/PACEMAKER			

PLEASE LIST ANY CURRENT MEDICATIONS:
HAVE YOU BEEN HOSPITALIZED? ☐YES ☐NO
PLEASE LIST ANY KNOWN ALLERGIES:
PLEASE LIST ANY ACCIDENTS OR PRIOR INJURIES: (CAR ACCIDENT/FALL/BROKEN BONES)

PATIENT SIGNATURE: _____ DATE: _____

PARENT / GUARDIAN SIGNATURE: _____ DATE: _____

REVIEWED BY PHYSICIAN: _____ DATE: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to u undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science of art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you week the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of_____
have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle_____

_____	_____
(signature)	(date)

Platinum Health & Wellness
485 Harmon Meadow Blvd
Secaucus, NJ 07094

In order to provide for the most effective healing environment, most effective application of procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declaration that will facilitate the goal of optimum health.

To that end, we ask that you acknowledge the following points regarding your care and the services that are offered through this clinic:

1. Chiropractic treatment includes spinal adjustments. The chiropractic adjustment process, as defined in the State of New Jersey involves the application of a specific directional thrust to a region or region of the spine. Adjustments can also be performed on extremities, including but on limited to: shoulders, knees, hips, wrists, elbows and jaws.
   Physical therapy may include but is not limited to: exercises, traction, stretching, electrical stimulation, therapeutic ultrasound, dry whirlpool, neuro-muscular reeducation, myofascial release and therapeutic activities.
2. We do not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical/dental conditions. We do not offer advice regarding treatment prescribed by others.
3. Your compliance with care plans, home and self-care is essential to maximum healing and optimal health.
4. We invite you to speak frankly to the doctor on any matter related to your care at this facility; including but not limited to the nature of your care, its duration or cost.
5. It is your responsibility to fully report your medical history and any changes in your healthy or any medical condition.
6. Payment for your treatment is your responsibility.
7. **IF YOU RECEIVE PAYMENT(S) FROM YOUR INSURANCE COMPANY FOR SERVICES PERFORMED AT OUR OFFICE IT IS YOUR RESPONSIBILITY TO FORWARD THAT PAYMENT WITH COPIES OF THE ACCOMPANYING DOCUMENTATION TO OUR OFFICE WITHIN SEVEN (7) DAYS.**
8. If you need forms filled out or a letter for your employer or any other party, please allow three (3) business days for it to be completed.
9. The supervision of children is the sole responsibility of the adult that accompanied them to the office. Please do not ask staff to supervise children.
10. It is your responsibility to report any change in your insurance, address or phone number.

I, _____ have read and fully understand the above statements.

(Print Name)

All questions pertaining to my care in this office have been answered to my satisfaction.

_____ ____/____/_____

(Signature) (Date)

Assignment of Rights and Benefits

I hereby instruct and direct my insurance company to pay the following provider direct payment for services rendered:

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485 Harmon Meadow Blvd
Secaucus, NJ 07094

If policy provision prohibit direct payment to physician, I hereby request payment for services rendered per current policy provision. Payment is for the profession or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward charges for profession 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 current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Assignment of Rights and Benefits 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.

_____
Signature of Policy Holder

_____
Date

_____
Witness

Hardship Agreement

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To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged as to allow me to receive chiropractic care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced, due to economic reasons, to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in this office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that is it my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payment.

_____ _____
Print Patient Name Date

_____
Patient Signature