

DATE _____	I.D. NO. _____
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PERSONAL HISTORY

Name: _____ Address: _____
 City: _____ State/Prov: _____ Zip/Postal Code: _____
 Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
 Social Security # _____ Driver's License Number: _____
 E-Mail Address: _____ Circle One: Married Single Widowed Divorced Separated
 Business Employer: _____ Type of Work: _____
 Business Phone: _____ Spouse's Social Security # _____
 Name of Spouse _____ Spouse's Social Insurance # _____
 Spouse's Employer _____ Business Phone _____
 Type of Work _____ Names and Ages of Children _____
 Referred To This Office By: _____
 Name and Number of Emergency Contact: _____ Relationship: _____
 Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Card # _____

CURRENT HEALTH CONDITION

Purpose of This Appointment _____
 Other Doctors Seen For This Condition: Yes No Who? _____
 Type of Treatment: _____ Results: _____
 When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
 Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
 Date of Accident: _____ Time of Accident: _____
 Have You Made A Report of Your Accident To Your Employer: Yes No
 Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other _____
 Do You Wear A Shoe Lift? Yes No
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
 Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____
 Major Accident or Falls: _____
 Hospitalization (Other Than Above): _____
 Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

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

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

- INTAKE**
- Coffee
 - Tea
 - Alcohol
 - Cigarettes
 - White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM CODE

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

GENERAL CODE

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

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

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

EENT CODE

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

MALE/FEMALE CODE

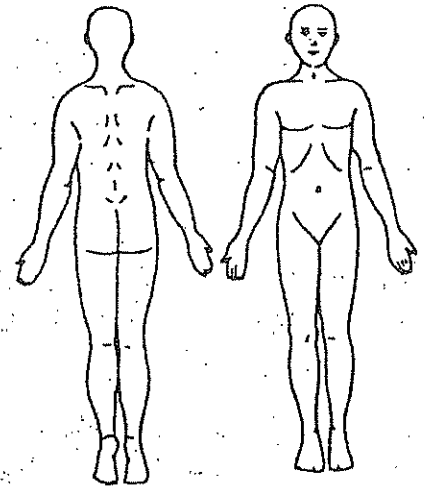
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? ____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

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

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature

Denville Medical & sports Rehabilitation Center
161 East Main Street
Denville, NJ 07834
Phone: (973) 627-7888
Fax: (973) 627-7040

1. Does the staff at Denville Medical & sports Rehab Center have permission to leave messages on your home answering machine concerning your specific medical information and/or your appointment/surgery information? (Please circle one below)

YES

NO

Home Phone #: _____

2. Does the staff at Denville Medical & Sports Rehab Center have permission to call you on your cell phone?

YES

NO

If yes; please check one of the following:

Leave a message on your voice mail with detailed information.

Leave a message with call back number if no voice mail is available.

Cell Phone #: _____

3. Does the staff at Denville Medical Center have permission to send you faxes?

YES

NO

Fax #: _____

4. Does the staff at Denville Medical Center have permission to send you e-mails?

YES

NO

E-mail: _____

5. Does the staff at Denville Medical Center have permission to call you at work?

YES

NO

If yes; please check one of the following:

Leave a message on your voice mail with detailed information

Leave a message with call back number if no voice mail is available.

Work Phone #: _____

I, _____ have received and have agreed to read the Privacy policy for Denville Medical & Sports Rehab Center.

Signature: _____ Date: _____

Denville Medical & Sports Rehabilitation Center
 161 East Main Street, Denville NJ 07834
 Phone: (973) 627-7888
 Fax: (973) 627-7040

Fall Prevention, Balance and Dizziness Survey

Prior to you Balance Trak 500(tm) test, please take a moment to answer this short survey about unsteadiness, balance and dizziness. Thank You.

Name (Please Print)	Age	Sex	Phone Number
Date of Birth	Height		

Please circle your answer

- | | | | |
|--|-------|-----------|-------|
| 1. Do you ever lose your balance or feel dizzy or unsteady? | Often | Sometimes | Never |
| 2. Are you dizzy or unsteady when you first get up? | Often | Sometimes | Never |
| 3. Do you worry that you may fall and hurt yourself? | Often | Sometimes | Never |
| 4. Does walking down the aisle of a supermarket or stopping next to a moving object, make you dizzy? | Often | Sometimes | Never |
| 5. Does moving your head quickly make you dizzy? | Often | Sometimes | Never |
| 6. Does bending over make you dizzy? | Often | Sometimes | Never |
| 7. Do dizziness or imbalance interfere with your job or your household responsibilities? | Often | Sometimes | Never |
| 8. Do people seem to mumble when they speak? | Often | Sometimes | Never |
| 9. Do your spouse or friends want the TV volume turned down to low or make remarks about your hearing? | Often | Sometimes | Never |

Release: I consent to the fall risk screening, which may include taking a history of fall risks, a computerized Balance test on hard and perturbed surfaces. I expressly acknowledge and agree to release Denville Medical & Sports Rehabilitation Center, their staff and all representatives from any and all responsibilities and/ or liabilities, and expressly waive any and all rights and privileges.

DENVILLE MEDICAL & SPORTS REHABILITATION CENTER
161 EAST MAIN STREET
DENVILLE, NJ 07834
PHONE: (973) 627-7888
FAX: (973) 627-7040

OFFICE FINANCIAL POLICY

Patients are required to complete ALL necessary paperwork.

Changes in appointments require advance notice. Please notify the office as soon as possible to reschedule your appointment. This will insure you get the treatment results you deserve.

Patients without insurance coverage are expected to pay (in form of cash, check or credit card) the same day services are rendered.

For our patients with assignable insurance coverage we have made an effort to remove the financial burden of you health care bills. We are one of the few health care providers that will accept assignment of benefits our center will render treatment and wait to be reimbursed by your insurance company.

We will assist you in any way we can with your insurance carrier, but any insurance or financial obligations are the full responsibility of the patient.

HMO/PPO's- PLEASE be secure that we are participating your plan, any precertifications/referrals are the patients responsibility.

This office is unique in its ability to offer Medical, Chiropractic, Physical Therapy, and Podiatry services. Please understand that if any treatment is prescribed, it is done on the basis of medical necessity, in order to resolve your condition and prevent recurrence.

Please feel free to ask any questions that remain unanswered, we wish to be of assistance in any way we can.

THANK YOU FOR CHOOSING DENVILLE MEDICAL AND SPORTS REHABILITATION CENTER FOR YOU HEALTHCARE NEEDS!!!!!!!

X _____
Patients Signature

X _____
Date

Practice Name _____
Address _____
City, State, Zip _____
Phone _____

Date _____

Patient _____
Employer _____
Claim Group _____
SS#/ID# _____

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

**DENVILLE MEDICAL & SPORTS
REHABILITATION CENTER
161 EAST MAIN STREET
DENVILLE, NJ 07834
Phone (973)-627-7888
Fax (973)627-7040**

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

**161 East Main St (Rt. 53)-Denville, NJ 07834
Phone (973) 627-7888 Fax (973) 627-7040**

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward 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.

Date: X _____

X _____
Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder.

DENVILLE MEDICAL & SPORTS REHABILITATION CENTER
161 EAST MAIN STREET, 2ND FLOOR
DENVILLE, NJ 07834

PHONE: (973) 627-7888
FAX: (973) 627-7040

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

I, _____ acknowledge that I have read and
understand the notice of Privacy Practices posted in the waiting room of Denville
Medical & Sports Rehabilitation Center.

Patient Signature

Date

INFORMED CONSENT FOR PROCEDURE

I hereby consent to the performance of medical procedures, including diagnostic x-rays and various forms of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor named below, and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serve as back up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of procedures.

I understand and am informed that, in the practice of medicine, there are some risks to treatment including, but not limited to sprains, fractures, strokes, disk injuries, and dislocations. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and wish rely on the doctor to exercise, judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name X _____ Signature of Patient X _____
Please print

Date signed X _____ Witness or Patient's Signature _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR LEGALLY OR PHYSICALLY INCAPACITED

Patient's Name _____ Signature of Patient _____
Please print

Date Signed _____ Signature of Representative _____

Relationship or Authority of Patient's Representative _____
(If Guardian, copy of order is required)

Translated by _____ Date _____

TO BE COMPLETED BY DOCTORS OR STAFF

Name of clinic or office _____
Address _____

Name of Doctor's treating this Patient _____

1. _____ Pin#

2. _____ Pin#

3. _____ Pin#

PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radical exposure has been explained to my satisfaction. I understand the clinical necessity of having x-rays at this time and give my permission for this procedure. In doing so, I release the doctor from responsibility of potential damage arising from this procedure.

At the present time:

- I am sure that I am NOT pregnant.
- It is possible that I could be pregnant.
- I am pregnant.

X _____

Signature of Patient

Date: X _____

Witness