



## CONFIDENTIAL PATIENT INFORMATION

Welcome to our office! Please complete all questions. Thank you.

Name: \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Address: \_\_\_\_\_ City, \_\_\_\_\_ State, \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
 Marital Status:  S  M  W  D Spouse's Name: \_\_\_\_\_  
 # of Children: \_\_\_\_\_ Children's ages: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Who is financially responsible for bills incurred in this office? \_\_\_\_\_  
 Method of payment: Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_  
 How did you find out about Frasco Chiropractic Office? \_\_\_\_\_  
 Who can we thank for referring you to our office? \_\_\_\_\_

### Symptoms

Reason for visit: \_\_\_\_\_ When did you first notice the symptoms? \_\_\_\_\_  
 Is the condition getting progressively worse? \_\_\_\_\_ Where specifically is the problem(s) located? \_\_\_\_\_  
 Which activities are difficult to perform?  Sitting  Standing  Walking  Bending  Lying down  Other  
 Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other  
 Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10  
 Is the pain constant or does it come and go? \_\_\_\_\_  
 What treatment have you received for your condition?  
 Medication  Surgery  Physical Therapy  
 Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_  
 Dr. \_\_\_\_\_ Address: \_\_\_\_\_ City, \_\_\_\_\_ State, \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Have you had chiropractic treatment before?  Yes  No If yes, when? \_\_\_\_\_  
 Dr. \_\_\_\_\_ Address: \_\_\_\_\_ City, \_\_\_\_\_ State, \_\_\_\_\_ Zip Code \_\_\_\_\_

### Health History Check only those conditions which are applicable:

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Depression          | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors, Growths    |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostrate Problems   | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever _____  |   |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Stroke _____         |   |

Dates of last exams: \_\_\_\_\_  
 (Woman) Are you pregnant?  Yes  No Nursing?  Yes  No Taking Birth Control Pills?  Yes  No  
 List any types of surgeries which you have had and the dates which they occurred: \_\_\_\_\_  
 Please list all medications you are currently taking: \_\_\_\_\_  
 Allergies: \_\_\_\_\_



All information is strictly confidential. Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e., TB, Hepatitis.

All first visit charges are payable when services are rendered, unless other arrangements are made in advance. Thank you.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Frasco Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to Frasco Chiropractic Office will be credited to my account upon receipt. **However**, I clearly understand and agree that I am personally responsible for payment of my account.

\_\_\_\_\_  
*Patient's Signature and Date*

\_\_\_\_\_  
*Guardian's Signature authorizing care for Minor*

In case of emergency, please notify: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICE (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. Frasco Chiropractic, we are very careful to keep your health information secure and confidential. This new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Frasco Chiropractic.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. Open adjusting involves adjusting patients in a semi-private setting. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

The use of this format is intended to make your experience with our office more efficient and productive; it is our goal to reduce waiting times as much as possible. If you choose not to be adjusted in an open adjusting environment, a private room is always available.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Frasco Chiropractic Office, LLC.**  
**1806 Springfield Avenue, New Providence, NJ 07974**  
**Telephone: (908) 771- 0707 - Fax: (908) 665 2067**



## **PLEASE MAKE A NOTE OF OUR OFFICE HOURS!**

Regular adjustments are done during **adjustment hours** ONLY. This is so that we may set aside uninterrupted time for scheduled reports. If you cannot make your adjustment time, kindly call the office and we will reschedule you for the next adjustment hour session.

X-rays, reports, and extended office visits are done during **report hours** ONLY. If you have a new injury or problem, you will need to schedule extra time with Dr. Frasco during the report hours. This way the doctor can spend uninterrupted time with you to correctly evaluate your condition. Please do not come to the office during your adjustment time asking for the doctor to evaluate a new condition or injury. This causes a unnecessary increase in waiting times for other patients.

**On Tuesday nights, Dr. Frasco gives the New Patient Workshop promptly at 6:00 p.m. This workshop is required for all new patients. Your home exercises will be given following the workshop. We encourage you to attend additional workshops as many times as you like since they all have different health information, and remember we welcome your friends and family!**

### **Monday, Wednesday, Thursday**

Adjustment hours	7:00 a.m. - 8:45 a.m.
Report hours	9:00 a.m. - 10:30 a.m.
Adjustment hours	10:30 a.m. -12:00 a.m.
Adjustment hours	2:30 p.m. - 3:15 p.m.
Report hours	3:30 p.m. - 4:15 p.m.
Adjustment hours	4:30 p.m. - 6:00 p.m.

### **Tuesday**

Adjustment hours	2:30 p.m. - 3:15 p.m.
Report hours	3:30 p.m. - 4:15 p.m.
Adjustment hours	4:30 p.m. - 6:00 p.m.

### **Saturday**

Adjustment hours	8:00 a.m. - 11:00 a.m.
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