WELCOME! Today's Date _____

Social Security No: _____ Driver's License: _____

Name: _____ Home phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Birth Date: _____ Marital status: M S W D, # of Children: ____ Occupation: _____

Employer: _____ Address: _____ Office #: _____

Name of Spouse _____ Employer: _____ Office #: _____

Emergency Contact: _____ Relationship:_____ Phone #: _____

Whom may we thank for referring you?: _____

Have you had previous Chiropractic Care? When?:_____
Why? _____

PLEASE GIVE AS COMPLETE A PERSONAL AND FAMILY HEALTH HISTORY AS POSSIBLE

What treatment have you already received for your present condition? Check all that apply.
[ ] Medication [ ] Physical Therapy [ ] Surgery [ ] None

Have you suffered from?	Do you have personal or family history of?		
[ ] neck pain	[ ] headache/migraines	[ ]	[ ]
[ ] neck stiffness	[ ] asthma	[ ]	[ ]
[ ] upper back pain	[ ] depression	[ ]	[ ]
[ ] mid back pain	[ ] anxiety	[ ]	[ ]
[ ] low back pain	[ ] high blood pressure	[ ]	[ ]
[ ] shoulder pain	[ ] heart condition	[ ]	[ ]
[ ] chest pain	[ ] digestive disorders	[ ]	[ ]
[ ] leg pain or numbness	[ ] ulcers	[ ]	[ ]
[ ] cramping of limbs	[ ] allergies	[ ]	[ ]
[ ] difficulty bending/lifting	[ ] cancer	[ ]	[ ]
[ ] difficultly rising/standing/sitting	[ ] diabetes	[ ]	[ ]
[ ] pain in the joints	[ ] tremors	[ ]	[ ]
[ ] arthritis	[ ] kidney problems	[ ]	[ ]
[ ] carpal tunnel	[ ] fainting	[ ]	[ ]
[ ] numbness or swelling in hands/feet	[ ] liver problems	[ ]	[ ]
[ ] cold hands/feet	[ ] bronchitis	[ ]	[ ]
[ ] dizziness	[ ] seizures	[ ]	[ ]
[ ] frequent ear infections or hearing loss	[ ] menstrual problems	[ ]	[ ]
[ ] frequent colds	[ ] learning disorders	[ ]	[ ]
[ ] flu	[ ] tremors	[ ]	[ ]
[ ] emphysema	[ ] fatigue	[ ]	[ ]
[ ] sinus trouble or pain behind eyes	[ ] other _____		

Have you lost time from work Y or N? If yes, how long:_____

Does your condition interfere with [ ] work [ ] sleep [ ] daily routine [ ] recreation?

Which are you interested in? _____Relief of disease, symptoms or infirmities.
_____Preventing disease, symptoms or infirmities.
_____Maximizing personal health potential.
_____Improving family and/or community health.

Are you currently on any medication? Y or N Please list:_____

Any previous injuries/surgeries? Y or N, If yes what and when? _____

INSURANCE INFORMATION (PLEASE PROVIDE CARE TO STAFF FOR COPYING)

Automobile Accidents: Have you been in an auto accident Y or N When? _____
Name of insurance company: _____ Policy number _____
Name and phone number of attorney (if applicable) _____

Accident at work or slip and fall on other's property:
Have you had a personal injury, slip and fall or work related accident Y or N When? _____
Name of insurance company:_____ Policy number _____
Name and phone number of attorney (if applicable) _____

Traditional Health Insurance: Do you have health insurance Y or N?
Name of insured _____ Relationship (circle one): Self Spouse Parent
Name of company _____ Policy number _____
Are you covered by Medicare Y or N? Identification number _____
Are you covered by Medicaid Y or N?, Is it an HMO Y or N?

SINCE VERIFICATION OF COVERAGE CANNOT BE DONE IMMEDIATELY, HOW WILL YOU BE PAYING FOR THIS VISIT? ____ Cash ____ Check _____ Visa/MC/Amex

IMPORTANT - - PLEASE READ!

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. **If any outstanding balance is overdue more than 30 days after the date I suspend or terminate my care, a finance charge of 18% will be added to overdue balances.**
Patient's signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check made out mailed to this clinic the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient's Signature: _____ Date: _____

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case; and hereby release the clinic of any consequence thereof.

Patient's Signature: _____ Date: _____

VERIFICATION OF NON-PREGNANCY

I, _____, hereby notify all concerned, that I neither suspect nor know positively at this time that I may be or am pregnant. I release this clinic from any and all liability arising from any and all procedures, of a diagnostic or treatment nature with reference to the possibility of pregnancy.

Patient's Signature: _____ Date: _____

CONSENT TO TREATMENT OF MINOR

I, Being the parent of guardian of _____ A minor, the age of _____ do hereby consent, authorize and request Dr. George J. Lubertazzo, D.C. to administer such treatment deemed advisable, necessary or requested on the above minor. Date of birth of minor: _____

Signature of Parent or Guardian: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE
DR. GEORGE J. LUBERTAZZO, D.C. FAMILY CHIROPRACTOR
39 MEADOW RD. RUTHERFORD, NJ 07070

As required by the Privacy Regulations of HIPAA, I hereby acknowledge that I have read a current copy of Dr. George J. Lubertazzo, DC Family Chiropractic's "Notice of Privacy Practices" as posted in the office, revised April, 2003.

As required by the Privacy Regulations, the office manager of Dr. Lubertazzo's office was made available to explain the "Notice of Privacy Practices" as posted in the office to my satisfaction. As required by said regulations, I am aware that Dr. Lubertazzo has included a provision that reserves the right to change the terms of this notice and to make the new notice's provisions effective for all protected health information that it maintains.

Patient's Signature: _____ Date: _____

Good faith effort to obtain receipt: Patient declined to sign the ACKNOWLEDGMENT of receipt of notice but was made aware of the "Notice of Privacy Practice" as posted in the reception of the office.

Staff Signature: _____ Date: _____

PATIENT AUTHORIZATION FOR USE OF CREDIT CARD

___ Any insurance checks that I receive I will promptly bring to the office. IF I fail to do so within one week of receiving it, you may use my credit card listed below to collect the amount.
___ Any balance due on my account will be paid for and cleared within thirty (30) days of notification of the amount outstanding and due. If a balance remains past the thirty (3) day, I hereby authorize you to collect that amount in full on the credit card.
___ The signed credit card is for use only for service in this chiropractic office, Dr. George J. Lubertazzo, Family Chiropractic Center.

Patient's Name/Credit Card Holder: _____
Address: _____ City: _____ State: _____ Zip: _____
Type of Credit Card:____ Visa _____ MC _____ Amex _____ Discover _____
Credit Card Number: _____ Expiration date: _____
Patient's Signature: _____