SSM Spine and Sports Medicine

Call 212-986-3888
Monday - Friday 7am - 7pm

Welcome

ABOUT YOU

Today's Date: ☐☐☐ File Number: ☐

Patient Name: ☐ ☐ ☐

LAST FIRST MI

What you prefer to be called: ☐ Gender: ☐ Male ☐ Female

Birthdate: ☐☐☐ Age: ☐ SSN: ☐☐☐

Mailing Address: ☐

City: ☐ State: ☐ Zip: ☐

Home Phone #: ☐☐☐ Work Phone #: ☐☐☐ ext. ☐

Mobile Phone #: ☐☐☐ Other Phone #: ☐☐☐

Email Address: ☐

Referred By: ☐

Employer: ☐ How Long: ☐

Employer's Address: ☐

City: ☐ State: ☐ Zip: ☐

Occupation: ☐

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: ☐

Do you have children: ☐ Yes ☐ No How many? ☐

INSURANCE INFORMATION

Company Name: ☐

Address: ☐

City: ☐ State: ☐ Zip: ☐

Phone #: ☐☐☐ Insured's ID #: ☐

Group # (Plan, Local or Policy #): ☐

Insured's Name: ☐

Relation: ☐ Date of Birth: ☐☐☐

Insured's Employer: ☐

PLEASE INFORM DESK OF ADDITIONAL INSURANCE SOURCES.

REASON FOR VISIT

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic

Explain what happened: ☐

☐

Explain the pain & its location:

When did the condition begin:

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your Work Sleep Daily routine ?

If so, please explain:

Have you been treated by a Medical Physician for this condition? Yes No

If so, where?

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? Phone #:

IN EVENT OF EMERGENCY

Who should we contact?

Relation:

Home Phone #: Work Phone #: ext.

Who is your Medical Doctor?

Phone #:

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants

Blood thinners Tranquilizers Insulin

Other(s)

Do you have or ever had any of the following diseases or conditions?

Yes **No** Heart Attack / Stroke
Yes **No** Heart Surgery / Pacemaker
Yes **No** Heart Murmur
Yes **No** Congenital Heart Defect
Yes **No** Mural Valve Prolapse
Yes **No** Artificial Valves
Yes **No** Alcohol / Drug Abuse
Yes **No** Venereal Disease
Yes **No** Hepatitis
Yes **No** HIV+ / Aids
Yes **No** Shingles
Yes **No** Cancer
Yes **No** Frequent Neck Pain
Yes **No** Emphysema I Glaucoma
Yes **No** Anemia
Yes **No** High/Low Blood Pressure
Yes **No** Psychiatric Problems
Yes **No** Rheumatic Fever
Yes **No** Severe/Frequent Headaches
Yes **No** Kidney Problems
Yes **No** Ulcers / Colitis
Yes **No** Fainting/Seizures/Epilepsy
Yes **No** Sinus Problems
Yes **No** Asthma
Yes **No** Diabetes/Tuberculosis
Yes **No** Difficulty Breathing
Yes **No** Chemotherapy
Yes **No** Lower Back Problems
Yes **No** Artificial Bones / Joints
Yes **No** Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

List previous surgeries/treatments with dates:

List any **past** serious accidents with dates:

Family Health History:

Do you: Take Supplements or Vitamins? ☐ Yes ☐ No Exercise? ☐ Yes ☐ No

Are you one a special diet? ☐ Yes ☐ No Since: ☐☐☐☐

Do you smoke? ☐ Yes ☐ No How Much? ☐ packs/day How Long? ☐ years

Are you wearing: ☐ Heel Lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress? ☐ years Is it comfortable? ☐ Yes ☐ No

For women: Are you taking Birth Control? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No How Long? ☐ months Nursing? ☐ Yes ☐ No

ACCOUNT INFORMATION

Person ultimately responsible for account

Name:

Relation:

Billing Address:

City: State: Zip:

SSN: ☐☐☐ D.L.#:

Work Phone #: ☐☐☐

Payment method: ☐ CASH ☐ Check ☐ Credit Card

Enter card # (If accepted) Initials:

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in lull for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature Date

Adult ☐ Patient ☐ Parent ☐ Guardian ☐ Spouse ☐