# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## 2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## 3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

## 4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

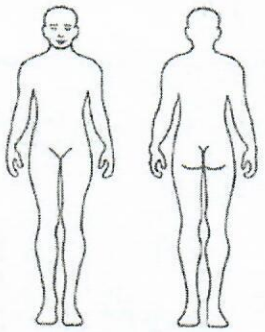
## 5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

## 6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV ☐ Yes ☐ No | Diabetes ☐ Yes ☐ No | Liver Disease ☐ Yes ☐ No | Rheumatic Fever ☐ Yes ☐ No |
| Alcoholism ☐ Yes ☐ No | Emphysema ☐ Yes ☐ No | Measles ☐ Yes ☐ No | Scarlet Fever ☐ Yes ☐ No |
| Allergy Shots ☐ Yes ☐ No | Epilepsy ☐ Yes ☐ No | Migraine Headaches ☐ Yes ☐ No | Sexually Transmitted Disease ☐ Yes ☐ No |
| Anemia ☐ Yes ☐ No | Fractures ☐ Yes ☐ No | Miscarriage ☐ Yes ☐ No | Stroke ☐ Yes ☐ No |
| Anorexia ☐ Yes ☐ No | Glaucoma ☐ Yes ☐ No | Mononucleosis ☐ Yes ☐ No | Suicide Attempt ☐ Yes ☐ No |
| Appendicitis ☐ Yes ☐ No | Goiter ☐ Yes ☐ No | Multiple Sclerosis ☐ Yes ☐ No | Thyroid Problems ☐ Yes ☐ No |
| Arthritis ☐ Yes ☐ No | Gonorrhea ☐ Yes ☐ No | Mumps ☐ Yes ☐ No | Tonsillitis ☐ Yes ☐ No |
| Asthma ☐ Yes ☐ No | Gout ☐ Yes ☐ No | Osteoporosis ☐ Yes ☐ No | Tuberculosis ☐ Yes ☐ No |
| Bleeding Disorders ☐ Yes ☐ No | Heart Disease ☐ Yes ☐ No | Pacemaker ☐ Yes ☐ No | Tumors, Growths ☐ Yes ☐ No |
| Breast Lump ☐ Yes ☐ No | Hepatitis ☐ Yes ☐ No | Parkinson's Disease ☐ Yes ☐ No | Typhoid Fever ☐ Yes ☐ No |
| Bronchitis ☐ Yes ☐ No | Hernia ☐ Yes ☐ No | Pinched Nerve ☐ Yes ☐ No | Ulcers ☐ Yes ☐ No |
| Bulimia ☐ Yes ☐ No | Herniated Disk ☐ Yes ☐ No | Pneumonia ☐ Yes ☐ No | Vaginal Infections ☐ Yes ☐ No |
| Cancer ☐ Yes ☐ No | Herpes ☐ Yes ☐ No | Polio ☐ Yes ☐ No | Whooping Cough ☐ Yes ☐ No |
| Cataracts ☐ Yes ☐ No | High Blood Pressure ☐ Yes ☐ No | Prostate Problem ☐ Yes ☐ No | Other _____ |
| Chemical Dependency ☐ Yes ☐ No | High Cholesterol ☐ Yes ☐ No | Prosthesis ☐ Yes ☐ No | |
| Chicken Pox ☐ Yes ☐ No | Kidney Disease ☐ Yes ☐ No | Psychiatric Care ☐ Yes ☐ No | |
| | | Rheumatoid Arthritis ☐ Yes ☐ No | |

### EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

### WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

### HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

## 7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

## ALLERGIES

## VITAMINS/HERBS/MINERALS

# WEST BROWARD WELLNESS CENTER, INC
# REVIEW OF SYSTEMS

**PATIENTS NAME:**_____ **DOB:**_____ **DATE:**_____

**TREATING PHYSICIAN:**_____

Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please identify if this is a problem that you currently have.

| | | Yes | No | Current | Explain |
|---|---|---|---|---|---|
| **Consitution:** | Sudden weight loss or gain? | ___ | ___ | ___ | _____ |
| **Eyes:** | Changes in vision? | ___ | ___ | ___ | _____ |
| | Watering, itching, burning? | ___ | ___ | ___ | _____ |
| | Pain or pressure? | ___ | ___ | ___ | _____ |
| **Ears:** | Changes in hearing? | ___ | ___ | ___ | _____ |
| **Nose:** | Bleeding or discharge? | ___ | ___ | ___ | _____ |
| **Mouth:** | Blisters in mouth? | ___ | ___ | ___ | _____ |
| **Throat:** | Throat pain? | ___ | ___ | ___ | _____ |
| **Cardio** | Chest pain? | ___ | ___ | ___ | _____ |
| **vascular:** | Palpitations? | ___ | ___ | ___ | _____ |
| | Ankle swelling? | ___ | ___ | ___ | _____ |
| **Respiratory:** | Difficulty breathing? | ___ | ___ | ___ | _____ |
| | Coughing? | ___ | ___ | ___ | _____ |
| **Gastro-** | Abdominal pain? | ___ | ___ | ___ | _____ |
| **Intestinal:** | Blood in stool? | ___ | ___ | ___ | _____ |
| | Any color changes in stool? | ___ | ___ | ___ | _____ |
| **Genito -** | Frequent urination? | ___ | ___ | ___ | _____ |
| **Urinary:** | Blood in urine? | ___ | ___ | ___ | _____ |
| | Painful urination? | ___ | ___ | ___ | _____ |
| **Musculo -** | Joint pain? | ___ | ___ | ___ | _____ |
| **Skeletal:** | Muscle pain? | ___ | ___ | ___ | _____ |
| **Neurologic:** | Headaches? | ___ | ___ | ___ | _____ |
| | Numbness, tingling? | ___ | ___ | ___ | _____ |
| **Hematologic/** | Swollen glands? | ___ | ___ | ___ | _____ |
| **Lymphatic :** | Bleeding problems? | ___ | ___ | ___ | _____ |
| **Endocrine:** | Increased thirst? | ___ | ___ | ___ | _____ |
| | Changes in temperature? | ___ | ___ | ___ | _____ |
| **Skin:** | Rashes? | ___ | ___ | ___ | _____ |
| | Itching? | ___ | ___ | ___ | _____ |
| **Allergic/** | Allergies? | ___ | ___ | ___ | _____ |
| **Immunologic:** | Immune disorders? | ___ | ___ | ___ | _____ |

# AUTO ACCIDENT INFORMATION

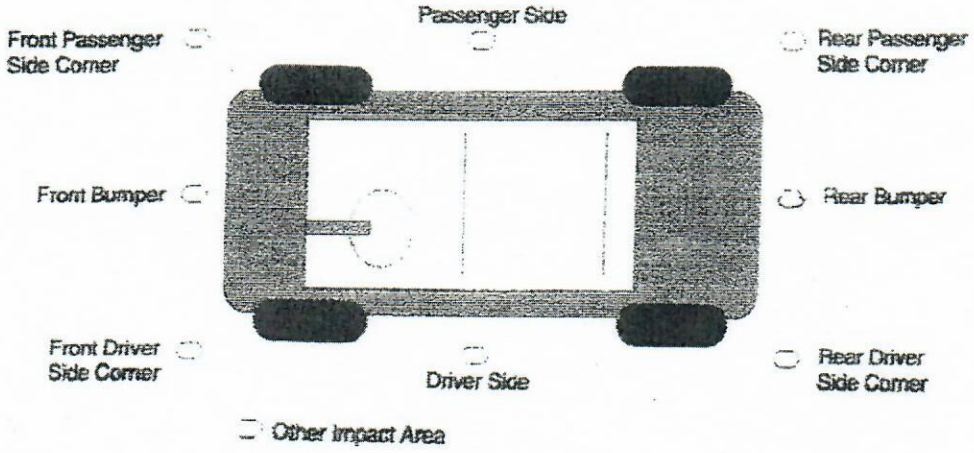
Patient's Name_____ Date of Birth:_____ Today's Date:_____
Address:_____ Date of Accident:_____
City:_____ State:_____ Zip:_____ Time of Accident:_____
Home #:_____ Work#:_____

Please describe how the accident happened
Just before the accident:

My vehicle was: ☐ at a traffic light ☐ at a stop sign going straight ☐ making a right left turn
☐ stopped for traffic ahead ☐ entering traffic from a side street/driveway
traveling at _____mph ☐ Other_____

Other vehicle: ☐ hit me in the rear ☐ ran a light ☐ making a ☐ right ☐ left turn
☐ entering traffic from a side street/driveway ☐ ran across my lane
other_____

Mark with "X" where you were sitting - and then fill in the bubble where your vehicle was hit:




☐ I was the driver Involved in a ☐ auto ☐ other type of accident in city_____ state_____
☐ I was the passenger sitting in the: ☐ middle front seat ☐ right front seat ☐ left rear seat
☐ middle rear seat ☐ right rear seat
Involved in a ☐ auto ☐ other type of accident in city_____ state_____

☐ I was a pedestrian: ☐ standing ☐ sitting ☐ riding a bike ☐ walking ☐ other

☐ I was traveling in a vehicle: Year: _____ Make:_____ Model:_____
Transmission type: ☐ manual ☐ automatic

Road conditions were: ☐ dry ☐ damp ☐ wet ☐ dark ☐ clear ☐ raining

Visibility was: ☐ poor ☐ fair ☐ good

The road was made of: ☐ concrete ☐ asphalt ☐ gravel ☐ dirt ☐ other_____
Did your car have a head rest: ☐ yes ☐ no
If your car had a head rest, what position was it in: ☐ up ☐ middle ☐ down

Were you: Wearing your seat belt? ☐ yes ☐ no Wearing your harness? ☐ yes ☐ no
Did your air bag deploy? ☐ yes ☐ no ☐ n/a
Head position: At the time of the accident my head was looking:
☐ straight ahead ☐ to the right ☐ to the left ☐up ☐ down ☐other_____

Brakes: Were your brakes applied at the time of impact? ☐ yes ☐ no

Elbows: My ☐ left ☐ right ☐ was on the arm rest. Other_____
Hands: ☐ both ☐ right ☐ left hand was on the steering wheel.
☐ Can't remember ☐ other_____

Were you aware of the impending collision before it happened:? ☐ yes ☐ no
Did you tighten your body and brace for the collision? ☐ yes ☐ no
Your hands, as a result of the impact:
☐ grabbed the steering wheel tightly ☐ were forced off the steering wheel / stick shift
☐ other_____

As a result of the impact, your body was thrown: ☐ forward ☐ backward ☐ right ☐ left
☐ turned to the right (clockwise) ☐ turned to the left (counter clockwise) ☐ can't remember

As a result of the impact, your head hit the: ☐ front windshield ☐ rearview mirror
☐ steering wheel ☐ back of the seat ahead of me ☐ side driver / passenger ☐ inside window / door
☐ another person's body ☐ back of my head hit the headrest ☐ other_____
☐ nothing

As a result of the impact, your shoulders were: ☐ impacted with the inside of the door / car
☐ pressed firmly against the shoulder harness ☐ other_____

As a result of the collision, what other parts of your body struck the inside of the vehicle:
☐ ankles ☐ elbows ☐ face ☐ chest ☐ thighs ☐ forearms
☐ other_____ ☐ other_____

Did another car hit you: ☐ yes ☐ no
Point of impact: ☐ head on ☐ rear end ☐ left front ☐ left rear ☐ right front ☐ right rear

Did your vehicle strike or impact with a second object after the first impact? ☐ yes ☐ no

Did your vehicle strike a ☐ Car ☐ truck ☐ road/median ☐ building ☐ other:_____

Were you wearing your glasses at the time of the accident? ☐ none ☐ yes ☐ no

If yes, were your glasses still on following the accident? ☐yes ☐ no

Did you lose consciousness as a result of the accident? ☐ yes ☐ no
If yes, how long were you unconscious: _____
Damage to my vehicle was ☐ mild ☐ moderate ☐ severe
Damage to other vehicle was ☐ mild ☐ moderate ☐ severe
Estimated cost to repair your car: $_____
After the accident the car was: ☐ totaled ☐ drivable ☐ not drivable
At the time of the accident, how many people were in the car with you: _____
Names of the occupants:
1._____
2._____
3_____
4._____
5._____
6._____

Were the other occupants injured? ☐ yes ☐ no If yes, explain:_____
Were the police called to the scene? ☐ yes ☐ no
Was a police report written? ☐ yes ☐ no
Was a ticket given to you? ☐ yes ☐ no

Was a ticket given to the other driver? ☐ yes ☐no
As a result of the accident I felt my symptoms:
☐ Immediately ☐ within one hour ☐ within 6 hours ☐ during the night
☐ Next morning ☐ Next day ☐ other_____
As a result of the accident I felt:
☐ headaches ☐ upper back pain ☐ chest pain/soreness ☐ wrist / elbow pain / soreness
☐ neck pain ☐ low back pain ☐ stomach pain/soreness ☐ knee/ankle pain/soreness
☐ shoulder pain ☐ numb/tingling/burning arms ☐ numb/tingling/burning legs
☐ loss of bowel / bladder control list all other symptoms_____
Please list location of any cuts or bruises if applicable:_____
Did you go to the hospital? ☐yes ☐ no
If no, where did you go? ☐ home ☐ work ☐ your primary Doctor

If yes: ☐ immediately ☐ next day ☐ later in same ☐ other_____
Did you go to the hospital by ☐ ambulance ☐ private transportation ☐ drove self
☐ someone else drove

Name of hospital_____ City_____

Were you admitted to hospital? ☐ yes ☐ no
If yes, how long was your stay:_____
Hospital treatment: ☐ Exams ☐ x-rays ☐ lab work

What follow-up recommendations were made? ☐ see your own doctor ☐ see orthopedist / neurologist
☐ physical therapist ☐ braces/collars ☐ released
☐ prescription: what types_____

Please list all doctors you have seen since the accident

| Doctor's Name | First Visit Date | Treatment | City | |
|---|---|---|---|---|
| 1._____ | | | | Released ☐ yes ☐ no |
| 2._____ | | | | Released ☐ yes ☐ no |
| 3._____ | | | | Released ☐ yes ☐ no |
| 4._____ | | | | Released ☐ yes ☐ no |

Are you working now? ☐ yes ☐ no
Were you employed at the time of this accident? ☐ yes ☐ no
Type of work you do-- Title:_____

Are you currently working with restrictions? ☐ yes ☐ no
Has the doctor placed you on: ☐ total disability ☐ partial disability ☐ does not apply
Please list work restrictions if any:_____

Please list any special tests ordered by the hospital or doctor:_____

Since the accident do you feel: ☐ worse ☐ no improvement ☐ better ☐ other_____

**% Of Improvement** 1 2 3 4 5 6 7 8 9 10 please circle with 10 being the very best

**Pain Scale** 1-10 with 10 being the worst: 1 2 3 4 5 6 7 8 9 10 please circle

ADDITIONAL NOTES:

# *Lien, Letter of Protection*

West Broward Wellness Center, Inc.
Kyzor M Dahdah, BS, DC  Teri Cohen-Dahdah, BA, DC
6846 North University Drive, Tamarac, FL 33321
Office: 954.474.3919  Fax: 954.474.1799
www.dahdahwellness.com
drdahdah@aol.com

RE: **Patient/Client:**
**Claim #:**
**DOA:**
**DOB:**

I_____ herby authorize and direct you, my attorney to pay directly to West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah sums as may be due and owing to West Broward Wellness Center, Inc for services rendered to me, both by accident or illness. I hereby give an irrevocable lien to West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah.

I direct my attorney to notify West Broward Wellness Center, Inc/Dr. Kyzor M Dahdah of any settlement, judgment or verdict. West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah will notify my attorney of all amounts due at the time fo closing or disbursement for the past consideration of received medical services. I also direct my attorney to notify West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah should he/she withdraw or is discharged from this case.

West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah has relied on these promises in providing medical services to me, I understand that I remain personally responsible for the total amount due to 'West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah. I further understand and agree that this lien and authorization does not constitute any consideration for West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah to await payments and they may demand payment from me immediately upon rendering services at their option. I give West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah and all its owned subsidiaries power of attorney to endorse any drafts that are made on my behalf for medical/Chiropractic services that were rendered.

I authorize West Broward Wellness Center, Inc/Dr. Kyzor M. Dahdah to release any information of my case to any insurance company, adjuster or attorney to facilitate collection under this Lien and Authorization.

_____

**Patient Signature:** **Date:**

_____

**Attorney Signature:** **Date:**

# WEST BROWARD WELLNESS CENTER, INC

## STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

**PATIENT NAME:** _____ **DOB:**_____

The_____ appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payments of your bill.

You are responsible for payment of any deductible and co payment/co insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to_____, for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to _____, the full and entire amount of bill incurred by me or the above names patient, or, if applicable any amount due after payment has been made by my insurance carrier.

**PATIENT SIGNATURE:**_____ **DATE:**_____

**GUARANTOR SIGNATURE:**_____ **DATE:**_____

### *CO PAY/CO INSURANCE POLICY*

Some health insurance carriers require the patient to pay a co pay/co insurance for services rendered. It is expected and appreciated at the time the service is rendered for the patient to pay at EACH VISIT. Thank you for your cooperation in this matter.

**PATIENT/GUARANTOR SIGNATURE:**_____ **DATE:**_____

### *CANCELLATION/NO SHOW POLICY*

We understand there may be times when you miss an appointment due to emergencies or obligations to work for family. However, we urge you to *CALL 24 HOURS PRIOR TO CANCELING YOUR APPOINTMENT.*

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The _____ will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described.

**PATIENT/GUARANTOR SIGNATURE:**_____ **DATE:**_____

# WEST BROWARD WELLNESS CENTER, INC

## INFORMED CONSENT FOR TREATMENT

**PATIENT NAME:**_____ **DATE:**_____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, ***but not limited to***, various modes of physical therapy, diagnostic x rays and spinal decompression, physical examination, or any other medical procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic associated with West Broward Wellness Center, Inc.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand an am informed that, as in the practice of medicine, in the practice of chiropractic ther are some risks to treatment including, ***but not limited to***, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to 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, and is in my best interest. Alternative treatments may include medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition. Any new condition other than what I am being treated for will be explained to me an a new consent will be signed.

_____

**PATIENTS SIGNATURE** **PATIENTS REPRESENTATIVE/GUARDIAN**

_____

**DOCTORS SIGNTURE** **DATE**

_____

**DIAGNOSIS**

# WEST BROWARD WELLNESS CENTER, INC

## ACKNOWLEDGEMENT OF RECEIPT
## OF
## NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for 6 years.

_____ _____

**Patient Name** (Please Print) **Date**

_____

Parent, Guardian or Patients legal Representative

_____

**Signature**

***This form will be placed in the patients chart and maintained for six years.***

List below the names and relationship of the people to whom you authorize, West Broward Wellness Center, Inc, to release PHI.

_____ _____

_____ _____

_____ _____

# WEST BROWARD WELLNESS CENTER, INC

6846 North University Drive
Tamarac, Florida 33321
Office: 954.474.3919 Fax: 954.474.1799
Email: recordswestbrowardwelllness@gmail.com
Kyzor M Dadah, BS, DC
Teri H Cohen, BA, DC

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical records of :

_____

Facility Name Patient Name

Date of birth: / / Last four digits of Social Security:_____

To: **West Broward Wellness Center, Inc/Kyzor M Dahdah, BS, DC**

***Please release the following:*** ___ *All records*

___ *Problem List* ___ *Progress Notes* ___ *Lab Reports*
___ *X Ray Reports* ___ *X Ray Films*
___ *History/Physcial Exam* ___ *Other Diagnostic Reports*

***Purpose of need Disclosure:***

___ *Continue Patient Care* ___ *Attorney/Legal*
___ *Insurance Claim/Application* ___ *Other*

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____

**PATIENT SIGNATURE OR LEGAL REPRESENTATIVE** **Date**