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) _____

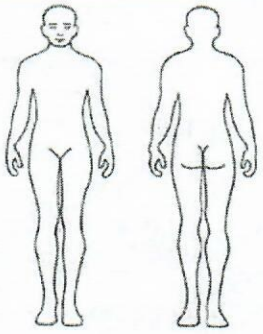
5 PATIENT CONDITION

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?	___	___	___	_____

West Broward Wellness Center, Inc./ Dr. Kyzor M Dahdah

Power of Attorney and Medical Release

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENEDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint West Broward Wellness Center, Inc./Dr. Kyzor M. Dahdah, and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any all checks, drafts or money orders which are payable to the undersigned alone or to the undersigned and the said West Broward Wellness Center, Inc./Dr. Kyzsor M. Dahdah which checks, drafts or money orders are made payable for services which have been made by West Broward Wellness Center, Inc./Dr. Kyzor M. Dahdah at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore the undersigned allows West Broward Wellness Center, Inc./Dr Kyzor M. Dahdah or any of its agents to sign any paper that will be necessary to enhance, expedite and/ allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said West Broward Wellness Center Inc./Dr Kyzor M. Dahdah as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intent and purposes as the undersigned might or could so to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to West Broward Wellness Center, Inc./Dr. Kyzor M. Dahdah or insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee page.

The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

Release of information: I hereby authorize this medical provider to: furnish my insurance company and companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer in NOT authorized to provide theses medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

ASSIGNMENT OF BENEFITS

I, _____ Hereby Authorize _____

To: (Name of Insured) (Name of Insurance Carrier)

Payable to and mailed directly to: West Broward Wellness Center, Inc./Dr. Kyzor M Dahdah 6846 N University Dr. Tamarac, FL 33321

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN West Broward Wellness Center, Inc./ Dr. Kyzor M. Dahdah any benefits under any policy of insurance, indemnity, agreement, or any other collateral source as defined in Florid Statutes for any service and or changes provided by West Broward Wellness Center, Inc./ Dr. Kyzor M. Dahdah IN WITNESS WHEREOF the undersigned have hereunto set their hands, this, _____ day of _____, 20___.

_____ _____

Patient's Signature Patient's Name (Please Print)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLKLUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
( )		( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	C.OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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**