Cicchini Chiropractic

CONFIDENTIAL PATIENT INFORMATION

First Name _____ *MI* ____ *Last Name* _____

Social Security # _____ - _____ - _____ *Gender* ___ Male ___ Female *Age*: _____

Birthdate: _____ / _____ / _____ *Marital Status* ___ Married ___ Single ___ Widowed

Address: _____

City: _____ *State*: _____ *Zip*: _____

Primary Ph. #: _____ *Secondary Ph. #:* _____

Email: _____

Occupation: _____ *Employer*: _____

Name of Spouse/Parent/Guardian (if applicable): _____

Spouse's Employer: _____ *Spouse's Occupation:* _____

EMERGENCY CONTACT

Name, Relation & Phone #: _____

Address (if different from patient): _____

How were you referred to this office?

___ Friend/Family Member ___Google ___ Our Website ___ Billboard ___ Yellow Pages

___Our Building Sign ___ Primary Doctor ___ Other (please explain) _____

INSURANCE INFORMATION

Do you have insurance? ___ Yes ___ No (If yes, our receptionist will need a copy of your ins. card)

Please check one or more of the following for your insurance coverage:

___ Private Insurance ___ Workers Compensation ___ Motor Vehicle Accident
___ Medicare ___Medicaid ___ Other

Insurance Company: _____

ID # or Claim #: _____

Insured's Name (if not the patient): _____

Patient Relationship to Insured: ___ Spouse ___ Parent ___ Child

Please Note: *Health and Accident insurance policies are in the arrangement between the carrier and the patient which are usually designed to offset a large of the total cost. This office will prepare any necessary reports and forms to assist in making collections from the insurance company to the patient or any amount authorized to be paid directly to this office will be credited to the patient's account. It should be understood that ALL services furnished are charged directly to the patient, who is personally responsible for payment. Payment is expected at the time of service, unless your insurance company covers chiropractic care at 100%. By signing below, I am agreeing that I fully understand I am responsible for all balances due.*

Patient's Signature: _____ Date: _____ / _____ / _____

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Check the symptoms you have experienced since the injury or illness began:

___ Headaches	___Pins/Needles, Arms	___Buzzing in Ears
___ Neck Pain	___Pins/Needles, Legs	___ Loss of Balance
___ Neck Stiffness	___ Numbness, Fingers	___ Fainting
___ Back Pain	___ Numbness, Toes	___ Loss of Smell
___ Nervousness	___ Fatigue	___ Loss of Taste
___ Tension	___ Depression	___ Diarrhea
___ Irritability	___ Light Hurts Eyes	___ Cold Feet
___ Chest Pain	___ Loss of Memory	___ Cold Hands
___ Dizziness	___ Ringing in Ears	___ Upset Stomach
___ Head Feels Heavy	___ Face Flushed	___ Constipation
___ Sleeping Problems	___Shortness of Breath	___ Cold Sweats

ACCIDENT INJURY INFORMATION

Date of Accident: _____ / _____ / _____ *Time*: _____ AM or PM

The accident was: ____ Auto Collision ____ Job Injury ____ Other Injury

*For **work related** injuries only*

Was supervisor/employer informed? ___ Yes ___ No
Did your employer recommend care at this office? ___ Yes ___ No

*For **auto accidents** only*

You were the: ____ Driver ____ Passenger ____ Pedestrian
You were struck from: ____ Behind ____ Front ____ Right Side ____ Left Side

Did you need post-accident hospitalization? ___ Yes ___ No

If so, which hospital did you go to? _____

Were X-rays taken? ___ Yes ___ No *Have you lost days from work?* ___ Yes ___ No

If you lost days from work, how many and which specific days?

_____

Do you have an attorney advising you on this claim? ___ Yes ___ No

Name: _____ Phone #: _____

Address: _____

Insurance Claim #: _____

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1. *What is your primary complaint?* _____

2. *What is the location of the complaint?* _____

3. *When did the pain start? (try to be specific)* _____

4. *The pain was:* ___Gradual ___ Sudden

5. *What type of pain is it?* ___ Sharp ___ Dull ___ Ache ___ Shooting
___ Pressure ___ Burning ___ Numb ___ Pins/Needles

6. *How long does it last?* ___ Constant ___ On & Off ___ Hours ___ Minutes

7. *How often do you have the pain?* ___ Daily ___ Several times per week
___ Few Hours/Day ___ Several times per month

8. *Does the pain travel or radiate to any other part of your body? If so, where?*

___ Legs (Right or Left) ___ Arms (Right or Left) Other: _____

9. *What aggravates the pain?*

___ Sitting ___ Standing ___ Twisting ___ Bending
___ Walking ___ Sneezing ___ Sleeping ___ Coughing

Other: _____

10. *What gives you relief?* ___ Heat ___ Ice ___ Massage ___ Medication

Other (please describe): _____

11. *Have you taken any medication in the past?* ___ Yes ___ No

12. *Are you presently taken medication?* ___ Yes ___ No

If so, what medication and for what conditions? _____

13. *Have you seen another Doctor for this condition?* ___ Yes ___ No

If so, what is the Doctor's name and phone #? _____
_____

What was done for you at this office? _____

14. *Have you had any recent surgery?* ___ Yes ___ No *If so, date & type?* _____

15. *Are you suffering from any other illness? If so, please describe*: _____

16. *What is the date of your last physical?* _____

17. *Is this your first chiropractic treatment?* ___ Yes ___ No

If not, who were you seeing before? _____

18. Please indicate any further comments: _____

_____

Cicchini Chiropractic

Dr. Perry J. Cicchini.
Dr. Jeannine Cicchini
805 S. Black Horse Pike
Blackwood, NJ 08012

ASSIGNMENT OF BENEFITS FORM

Patient's Name: _____

I irrevocably assign to Doctors Perry J. Cicchini and Jeannine Cicchini all my rights and benefits under any insurance contact for payment for services rendered to me by Doctors Perry J. Cicchini and Jeannine Cicchini. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by Doctors Perry J. Cicchini and Jeannine Cicchini to be release to Doctors Perry J. Cicchini and Jeannine Cicchini. I irrevocably authorize Doctors Perry J. Cicchini and Jeannine Cicchini to file insurance claims and law suits on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Doctors Perry J. Cicchini and Jeannine Cicchini. I irrevocably authorize Doctors Perry J. Cicchini and Jeannine Cicchini to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect and execute it voluntarily.

Patient's Signature: _____ Date: _____ /_____ /_____

Witness: _____

Cicchini Chiropractic

Dr. Perry J. Cicchini
Dr. Jeannine Cicchini
805 S. Black Horse Pike
Blackwood, NJ 08012

AUTHORIZATION RELEASE
MEDICAL RECORDS AND XRAYS

I, _____ hereby authorize the release of my X-rays and any other medical records or copies of such that may be pertinent to my condition.

Patient's Signature: _____ Date: _____ / _____ / _____

Please fax to:

Dr. Perry J. Cicchini, D.C., P.A.
805 S. Black Horse Pike
Blackwood, NJ 08012

(Fax) 856-228-9323
(Phone) 856-228-8888

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BILL CODING EXPLANATION FORM

CODE	EXPLANATION
DN	Spinal manipulation
L	Extraspinal manipulation
V	Vibratory Therapy
T	Traction
R	Rollerbed
W	Waterbed
BIF / BIO	Biofreeze
U	Ultrasound
S	Electrical Stim Machine
K	Carpal Tunnel Machine
ME / ME1	Spinal Manipulation Codes for Medicare patients
B6	Spinal Manipulation Code for Medicaid patients

By signing this form I am confirming that I have received a copy of Doctors Perry J. Cicchini's and Jeannine Cicchini's Billing Code Explanation Form.

Patient's Signature: _____ Date: _____ / _____ / _____

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PATIENT MEDICAL QUESTIONAIRE

Name: _____

Age: _____ *Height*: _____ *Weight*: _____ Race: _____

Smoker: ___ Yes ___ No *Former Smoker*: ___ Yes ___ No

Hypertension: _____ *Blood Pressure:* _____ *Pulse:* _____

Please list current medication(s):

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to medication(s) (if applicable):

_____

_____

Would you like to receive our monthly eNewsletter? ___ Yes ___ No