488 Pleasant Street | Worcester, MA 01609
Phone 508-752-7334 | Fax 508-752-8469

Name_____ Date of Birth_____ Sex M F

Address_____ City_____ State_____ Zip Code_____

Cell Phone_____ Home Phone_____

Occupation _____ Marital Status: M S W D CHILDREN #_____

Date of Accident_____ Time of Accident_____ Location_____

At the time of the accident you were the: **(PLEASE CIRCLE) DRIVER FRONT PASSENGER**

Right/Left/Middle BACK PASSENGER PEDESTRIAN MOTORCYCLE BICYLCE OTHER

Did you have your seatbelt on at the time of the accident? **YES NO**

Were you aware of the impending collision and did you attempt to brace? **YES NO**

What were the road conditions? **WET DRY SNOW ICE**

Did any airbags deploy? **YES NO** Were you knocked unconscious? **YES NO**

Did you strike your head or other body parts within the vehicle? **YES NO**

If yes, what and where?_____

Please explain how the accident occurred: _____

_____

_____

_____

Please list your pain and/or symptoms as a result of this accident:_____

_____

Did you go to a hospital or Doctor? If so, where and when?_____

_____

How did you go to the hospital or Doctor? **AMBULANCE DROVE SELF DRIVEN OTHER**

At the hospital or Doctor what treatment was given?_____

_____

Did you miss any time from work? **YES NO** IF YES, HOW LONG? _____

Since the accident are you symptoms: **IMPROVING WORSE SAME**

What positions or activities aggravate your condition?_____

What positions or activities relieve your condition?_____

Is you condition solely the result of this accident? **YES** **NO**

If no, please explain_____

Have you been involved in any previous auto accidents? **YES** **NO** If yes, when? Note injuries that resulted**:**

_____

List all medication that you are taking and what for:_____

_____

Please Check Any Significant Symptoms That You Have Experienced or Currently Experience

GENERAL
( ) ALLERGY
( ) CHILLS
( ) CONVULSION
( ) DIZZINESS
( ) FAINTING
( ) FEVER
( ) HEADACHE
( ) LOSS OF SLEEP
( ) LOSS OF WEIGHT
( ) NERVOUSNESS
( ) DEPRESSION
( ) SWEATS
( ) TREMORS

GASTRO-INTESTINAL
( ) CONSTIPATION
( ) DIARRHEA
( ) DIGESTIVE PROBLEMS
( ) GALL BLADDER PROBLEMS
( ) HEMORRHOIDS
( ) LIVER PROBLEMS
( ) NAUSEA
( ) STOMACH PAIN
( ) POOR APPETITE
( ) VOMITING
( ) VOMITING BLOOD
( ) COLON TROUBLE

MUSLCE & JOINT
( ) LOW BACK PAIN
( ) MUSCLE SPASMS
( ) NECK PAIN
( ) MID/UPPER BACK PAIN
( ) SWOLLEN JOINTS
PAIN/NUMBNESS IN THE:
( ) SHOULDERS
( ) ARMS
( ) ELBOWS
( ) HANDS
( ) HIPS
( ) LEGS
( ) KNEES
( ) FEET

SKIN
( ) BOILS
( ) BRUISE EASILY
( ) COLD SORES
( ) DRYNESS
( ) RASHES/HIVES
( ) VARICOSE VEINS

RESPIRATORY
( ) CHRONIC COUGH
( ) DIFFICULTY BREATHING
( ) COUGHING UP BLOOD
( ) COUGHING UP PHLEGM
( ) WHEEZING

EAR-NOSE-THROAT

( ) FREQUENT COLDS
( ) EARACHE
( ) EAR NOISES
( ) EYE DISCHARGE
( ) POOR VISION
( ) NOSE BLEEDS
( ) SINUS TROUBLE
( ) DEAFNESS
( ) EAR DISCHARGE
( ) ENLARGED GLANDS
( ) EYE PAIN
( ) DENTAL PROBLEMS
( ) NASAL OBSTRUCTION
( ) LARYNGITIS

GENITO-URINARY
( ) BED WETTING
( ) BLOOD IN URINE
( ) FREQUENT URINATION
( ) KIDNEY INFECTION
( ) PAINFUL URINATION
( ) PUS IN URINE
( ) KIDNEY PROBLEMS

CARDIOVASCULAR
( ) CHEST PAIN
( ) ARTERIOSCLEROSIS
( ) HIGH BLOOD PRESSURE
( ) LOW BLOOD PRESSURE
( ) POOR CIRCULATION
( ) RAPID HEAR BEAT
( ) SLOW HEART BEAT

HABITS
( ) ALCOHOL – AMOUNT PER DAY/HOW MANY YEARS? _____
( ) TOBACCO – AMOUNT PER DAY/HOW MANY YEARS?_____
( ) DRUGS – AMOUNT PER DAY HOW MANY YEARS?_____
( ) EXERCISE – AMOUNT PER WEEK_____

ARTIFICIAL PROSTHESES
( ) DENTURES
( ) CONTACT LENSES
( ) HEARING AID
( ) SURGICAL IMPLANTS

WOMEN ONLY – Please Check if Apply

ARE YOU PREGNANT? ( ) **YES** **( ) NO** ( ) CRAMPS ( ) EXCESSIVE FLOW ( ) HOT FLASHES

( ) IRREGULAR CYCLE ( ) LUMPS IN BREAST ( ) PAINFUL MENSTRUATION ( ) VAGINAL DISCHARGE

PAYMENT INFORMATION

Auto Insurance _____ Claim#_____

Health Insurance_____ Member ID#_____

I understanding agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. For certain personal health policies this may include services not payable per my personal health insurance policy, however allowable per my personal health insurance policy to be performed and charged to me. I understand that the office has the right to charge me for missed appointments.

DATE_____ PATIENT SIGNATURE_____

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations for the disclosure of your health information and your rights as a patient. Please note this document is also posted in the office and on our website. If you ever have any questions or concerns regarding the use of dissemination or your personal health information, we would be happy to address them.

I acknowledge I have received a copy of Giolekas Sports and Family Chiropractic, Inc.'s *Notice of Privacy Practices for Protected Health Information,* I also understand that this privacy notice is posted in the office and on giolekaschiropractic.com.

Printed Patient Name	Date
Patient Signature	Authorized Provider Rep
Personal Representative Printed	Personal Rep Signature

Description of personal representative's authority to act for the patient

GIOLEKAS SPORTS & FAMILY
CHIROPRACTIC

488 Pleasant Street | Worcester, MA 01609
Phone 508-752-7334 | Fax 508-752-8469

Insurance Benefit Determination

This office attempts to determine your insurance benefits based on the information we have at the time of service. However, insurance plans and insurance carriers are constantly changing and at times websites are not up to date. We will continue to provide you with the most up to date information that we have available.

However, it is your responsibility to have an understanding of your insurance coverage which may include mandatory referrals, copayments, co-insurance and/or deductibles.

Thank you for your understanding of this matter.

_____
Patient Name Printed

_____ _____
Patient Signature **Date**

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ASSIGNMENT OF INSURANCE BENEFITS

Patient Name_____

Date of Birth_____

I irrevocably authorize the _____ to make
(Insurance Company Name)
direct payment to Giolekas Sports and Family Chiropractic, Inc. at 488 Pleasant Street, Worcester, MA 01609 for any and all insurance benefits or reimbursement for services rendered by them which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

_____ _____
Date Patient's Signature

RELEASE OF INFORMATION

I authorize the release of any information concerning my health and health care service to my insurance companies, pre-paid health plan or Medicare by Giolekas Sports and Family Chiropractic, Inc.

_____ _____
Date Patient's Signature