Patient Enrollment Forms for:

UNIVERSITY CHIROPRACTIC CENTER

Today's Date: _____ /_____ / _____

Name:_____ Onset Date: _____ /_____ / _____

Address:_____ Apt: _____

City:_____ State: _____ Zip: _____

Alternate Address:_____

City:_____ State: _____ Zip: _____

Telephone: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____- _____

Birth date: _____ /_____ /_____ **Age:** _____ **Social Security #**:_____-_____-_____

Height:_____ **Weight**: _____ **Sex**: M / F **Ethnicity**: o Hispanic o Non-Hispanic

Marital Status: ▫ Single ▫ Married ▫ Divorced ▫ Widowed **Preferred Language**:_____

Appointment Reminders: Y / N ? Email or Text? (circle one) Race:_____

Email:_____ **Phone Carrier** (if text):_____

Confidential Communication Pref: (**circle one**) Cell / Home / Work / Email / Postal Mail / In Person

EMPLOYMENT INFORMATION

Are you: ▫ Employed ▫ Self-Employed ▫ Student ▫ Retired ▫ Other_____

Employer:_____ Occupation: _____

Address:_____ Apt: _____

City:_____ State: _____ Zip: _____

SPOUSE INFORMATION

Name:_____ Birthdate: _____ /_____ / _____

Employer:_____ Occupation: _____

Telephone: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____- _____

EMERGENCY CONTACT INFORMATION

Relative to contact in case of emergency:_____ Relationship:_____

Telephone: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____- _____

HOW DID YOU HEAR ABOUT US?

▫ Verizon Yellow Pages ▫ LWR Premier Pages ▫ Drive By/Walk In ▫ Internet Search

▫ Website ▫ Existing Patient/Friend:_____ ▫ Other: _____

o Facebook **o** Insurance Directory_____

What are your goals with Chiropractic care for this problem?

▫ **RELIEF CARE** (Patch this problem temporarily) ▫ **CORRECTIVE CARE** (Fix the problem)
When did the problem begin? _____ /_____ /_____
Have you ever had this problem before? **Yes / No** If **YES,** when? _____
Describe your current symptoms and what caused them (if possible):_____
_____
_____
Have you ever had Chiropractic treatment? **Yes / No** If **YES,** when was your last visit? _____
Name of Doctor (optional):_____ Was treatment successful? **Yes / No**
Have you seen any other doctors for this condition? **Yes / No** If **YES,** please describe treatment performed:_____

HEALTH HISTORY

Do you have any hereditary conditions in your immediate family? (Please check all that apply and indicate mother, father, brother, sister, grandfather, grandmother)

▫ **Heart Disease**_____ ▫ **Cancer**_____ ▫ **Arthritis**_____
▫ **Diabetes**_____ ▫ **Asthma**_____ ▫ **High Blood Pressure** _____
▫ **Other** _____ *Family member who have/had it:*_____
Do you currently suffer from any other medical problems? **Yes / No** If **YES,** please explain:
_____
List any hospitalizations you have had including dates: _____
List any major injuries / accidents: _____
List all prior surgeries including dates: _____
_____
Are you currently taking any medications? **Yes / No** If **YES,** please list:_____
_____

Medicinal Allergies: **Yes / No** If **YES**, please list: _____

DO YOU HAVE A HISTORY OF THE FOLLOWING?

Arthritis .....▫Yes ▫No	Fainting Spells .....▫Yes ▫No	Osteoporosis ..▫Yes ▫No
High Blood Pressure .....▫Yes ▫No	Ringing in Ears .....▫Yes ▫No	Headaches .....▫Yes ▫No
Poor Circulation .....▫Yes ▫No	Shortness of Breath..▫Yes ▫No	Fatigue .....▫Yes ▫No
Loss of Bladder Control ..▫Yes ▫No	Difficulty Walking .....▫Yes ▫No	Insomnia .....▫Yes ▫No
Frequent Urination .....▫Yes ▫No	Kidney Stones .....▫Yes ▫No	Diarrhea .....▫Yes ▫No
Blurred Vision .....▫Yes ▫No	Loss of Balance .....▫Yes ▫No	Indigestion .....▫Yes ▫No
Heartburn .....▫Yes ▫No	Hernia .....▫Yes ▫No	Nausea .....▫Yes ▫No
Dizziness.....▫Yes ▫No	Weight Gain/Loss .....▫Yes ▫No	Hearing Loss...▫Yes ▫No

SOCIAL HISTORY

How many hours a week do you work? _____ Are you: ▫ Sitting ▫ Standing ▫ Lifting ▫ Driving
Smoking Status: ▫ Never ▫ Former ▫ Occasional ▫ Daily
Do you drink alcohol? **Yes / No** If **YES,** how much?_____
How much water do you drink daily? _____
Do you exercise? **Yes / No** If **YES,** how often? _____

PREGANCY WARNING AND CONSENT FOR X-RAY

I, _____, hereby certify that to the best of my knowledge I am **NOT** pregnant and that the doctors of **UNIVERSITY CHIROPRACTIC CENTER, INC.**, have my permission to perform a diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child. I also agree to **notify UNIVERSITY CHIROPRACTIC CENTER, INC.**, in writing during the course of my treatment should I become pregnant.

Date of last menstrual period: _____/_____/_____

Patient Signature:_____ Date: _____/_____/ ___

AUTHORIZATION FOR TREATMENT AND CONSENT FOR CARE

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an insurance carrier and myself, however, UNIVERSITY CHIROPRACTIC CENTER, INC., may accept certain insurance assignments of benefits. I understand and agree that I am ultimately responsible for any payment that my insurance carrier or any third party payor does not pay. The acceptance of insurance is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable. Furthermore, I hereby voluntarily consent to examination, diagnostic treatment and/or Chiropractic care by UNIVERSITY CHIROPRACTIC CENTER, INC., it's physicians and employees, as explained to me by the attending physician and whomever he may designate as his assistant. I am aware that the science of Chiropractic Medicine in not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees have been made to me as a result of any treatment or examination in office.

Patient Signature:_____ Date: _____/_____/ ___

Guardian Signature:_____ Relationship: _____

ASSIGNMENT OF BENEFITS

I, _____, hereby authorize_____,
(Name of Insured/Patient) *(Name of Insurance Carrier)*
to make medical benefits payments otherwise payable to me for services rendered by **UNIVERSITY CHIROPRACTIC CENTER, INC.,** but not to exceed the charges of those services, payable to and mailed directly to:

UNIVERSITY CHIROPRACTIC CENTER, INC., 8223 Cooper Creek Blvd, University Park, FL 34201

Furthermore, I hereby IRREVOCABLY ASSIGN to **UNIVERSITY CHIROPRACTIC CENTER, INC.**, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and or charges provided by **UNIVERSITY CHIROPRACTIC CENTER, INC.**

IN WITNESS WHEREOF, the undersigned have hereunto set their hands, this _____ day of _____, 201____.

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

AUTHORIZATION FOR RELEASE OF RECORDS

TO: _____ DATE: _____/_____/_____

_____ FROM: University Chiropractic Center, Inc.
8223 Cooper Creek Blvd, University Park, FL 34201

I authorize and request you to release any and all records in your possession, including x-rays, concerning this patient:

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

PRIVACY RIGHTS ACKNOWLEDGEMENT FORM

I have received the **NOTICE OF PRIVACY PRACTICES** and I have been provided an opportunity to review it.

_____ _____

Patient's Signature Patient Name (Please Print)

Today's Date: _____/_____/_____ Patient's Birthdate: _____/_____/_____

8223 Cooper Creek Boulevard • University Park, FL 34201 • 941-360-2220 • Fax 941-360-2229

C. BRADY ARNSPERGER, D.C.
UNIVERSITY CHIROPRACTIC CENTER, INC.
8223 Cooper Creek Boulevard • University Park, FL 34201 • 941-360-2220 • Fax 941-360-2229

SIGNATURE ON FILE

- ☐ I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- ☐ I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- ☐ I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ☐ I authorize payment of health benefits otherwise payable to me, directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.
- ☐ This "SIGNATURE ON FILE" is valid for one year from the date indicated below.

_____ _____ _____/_____/_____

Signature Medicare # (if applicable) Date

_____ _____

Please print name of Signature Relationship toPatient

Revised May 2010