Multi-Care Medical

11270 Pines Blvd.| Pembroke Pines, FL 33026| PH 954.441.7246| FX 954.441.7241

ABOUT YOU:

TODAY'S DATE: _____PATIENT NAME:_____

SEX: ___MALE___FEMALE D/O/B: _____ AGE: _____ SS#: _____

ADDRESS: _____CITY/ST/ZIP: _____

HOME/CELL: _____

EMAIL: _____@_____.COM

I authorize to receive email/text messages for appointment reminders and general health reminders from this practice ___(PT INITIALS)

EMPLOYER: _____OCCUPATION: _____

STATUS: ___MINOR ___SINGLE ___MARRIED ___DIVORCED ___SEPARATED ___WIDOWED

SPOUSE: _____CHILDREN: ___YES ___NO IF SO, HOW MANY? ____

EMERGENCY CONTACT:

NAME: _____RELATION: _____PH #: _____

If a family member/friend asks to speak to you, can we tell them you are here: ___YES ___NO

REASON FOR YOUR VISIT:

REASON FOR THE VISIT: ____AUTO ____WORK ____SPORTS ____TRAUMA ____CHRONIC

EXPLAIN WHAT HAPPENED IN DETAIL:

_____

DESCRIBE THE PAIN AND LOCATION:

_____

DATE CONDITION BEGAN: _____|GETTING WORSE: ___Y___N|CONSTANT: ___COMES/GOES:___

IS THE CONDITION INTERFERRING WITH YOUR: _____WORK _____SLEEP _____DAILY ROUTINE

HAVE YOU HAD A SIMILAR CONDITION IN THE PAST? _____YES _____NO

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN? _____YES _____NO

HAVE YOU BEEN TREATED BY A CHIROPRACTOR BEFORE? _____YES _____NO WHOM? _____

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HEALTH HISTORY:

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

___BLOOD PRESSURE ___PAIN KILLERS (ASPIRIN) ___MUSCLE RELAXERS ___BLD THINNERS

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

	HEART ATTACK/STROKE		HEART SURG/PACEMAKER		HEART DISEASE
	ALCOHOL ABUSE		DRUG ABUSE		HIV/AIDS
	SHINGLES		VENEREAL DISEASE		DIABETES
	CANCER_____		SINUS PROBLEMS		GLAUCOMA
	RESPIRATORY ISSUES		KIDNEY PROBLEMS		ARTHRITIS
	ANEMIA		ASTHMA		HIGH / LOW BLOOD PRESS.
	HEPATITIS		FAINTING / SEIZURES		ULCER / COLITIS
	PSYCHIATRIC PROBLEMS		OTHER		_____

DO YOU HAVE ANY METAL IN YOUR BODY? (EX. BULLETS, IMPLANTS) ___YES ___NO

IF YES, PLEASE EXPLAIN: _____

LIST ANY SERIOUS MEDICAL CONDITION (S) YOU HAVE/HAD	
PLEASE LIST ANYTHING YOU MAY BE ALLERGIC TO	
LIST PREVIOUS SURGERIES/TREATMENTS WITH DATES	
LIST ANY PAST SERIOUS ACCIDENTS WITH DATES	

FAMILY HEALTH HISTORY:.

DO YOU TAKE SUPPLEMENTS OR VITAMINS? ___YES ___NO
EXERCISE? ___YES ___NO
SPECIAL DIET? ___YES ___NO
DO YOU SMOKE? ___YES ___NO

WOMEN:

PREGNANT? ___YES ___NO LAST MENSTRUAL CYCLE? _____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE:_____DATE:_____WITNESS:_____

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AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, patient in this office hereby authorize **Multi Care Medical** and/or the physicians of **Multi Care Medical** (and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment, the reason why the above-named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **Multi Care Medical** and/or the physicians of **Multi Care Medical**.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

Date: _____ Signed: _____

Witness: _____ Patient's Name: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDEGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____ Self _____Other ________________________

Signature: ____Date: _______

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OFFICE USE ONLY

WITNESS: ____