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? ___YES ___NO

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AUTO ACCIDENT RELATED:

DATE|TIME OF ACCIDENT: _______@____ AM / PM WERE YOU: ___DRIVER___FRONT PASS. ___REAR PASS.

WHO WAS CITED: ____SELF ____OTHER NUMBER OF PEOPLE IN THE VEHICLE? ______

DID THE POLICE COME OUT TO THE ACCIDENT SCENE? ___YES ___NO

	POLICE REPORT		WERE YOU WEARING YOUR SEATBELT
	WITNESSES		DID AIRBAGS DEPLOY

IN RELATION TO THE BASE OF YOUR SKULL, THE HEADREST WAS ___ABOVE ___BELOW ___AT BASE

WHAT DID YOU IMPACT? _____ANOTHER VEHICLE ______OTHER : ____________________________

ANY BODY PART STRIKE VEHICLE? _______________________________

MAKE/MODEL OF THE VEHICLE YOU WERE OCCUPYING? ____

STREET NAME ON WHICH YOU WERE TRAVELING? ____

DIRECTION YOU WERE HEADED? ___NORTH___SOUTH ___EAST ___WEST SPEED ? _______MPH

DID THE IMPACT TO YOUR VEHICLE COME FROM THE ___FRONT ___REAR ___RT SIDE ___LT SIDE

DURING THE IMPACT, WERE YOU FACING: ___RIGHT ___LEFT ____FORWARD

WERE YOU: ___AWARE ____SURPRISED | BY THE IMPACT

MAKE/MODEL OF THE OTHER VEHICLE? ____

DIRECTION THEY WERE HEADED? ___NORTH ___SOUTH ___EAST ___WEST SPEED ? _____MPH

DESCRIBE THE ACCIDENT IN DETAIL ____

____

____

____

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AFTER THE ACCIDENT:

WERE YOU RENDERED UNCONSCIOUS? ___YES ___NO IF YES, FOR HOW LONG? __________

PLEASE DESCRIBE HOW YOU FELT AFTER THE ACCIDENT: ________________________________

DID YOU GO TO THE HOSPITAL? ___YES ___NO IF YES, WHERE? ________________________

WHEN DID YOU GO? ___AFTER ACCIDENT ___NEXT DAY ___2+ DAYS X-RAYS? ___YES ___NO

	DIZZINESS		NAUSEA		BLURRED VISION
	MEMORY LOSS		IRRITABILITY		TENSION
	HEADACHES		JAW PAIN		CHEST PAIN
	SHOULDER PAIN __L__R		ELBOW PAIN __L__R		BUZZ/RINGING IN EAR (S)
	NUMB: ARMS HANDS FINGERS		NECK PAIN / STIFFNESS		DIFFICULTY SLEEPING
	WRIST / HAND __L __R		OTHER		

INDICATE YOUR DEGREE OF COMFORT WHILE PERFORMING THE FOLLOWING ACTIVITIES:

		COMFORTABLE	UNCOMFORTABLE	PAINFUL
LYING ON BACK		☐	☐	☐
LYING ON SIDE		☐	☐	☐
LYING ON STOMACH		☐	☐	☐
SLEEPING SITTING		☐	☐	☐
STANDING		☐	☐	☐
WALKING		☐	☐	☐
RUNNING		☐	☐	☐
SPORTS		☐	☐	☐
WORKING		☐	☐	☐
LIFTING		☐	☐	☐

HAVE YOU BEEN ABLE TO WORK? ___YES ___NO NUMBER OF HOURS IN A WORKDAY? _________

HAS YOUR WORK BEEN AFFECTED SINCE THE ACCIDENT? ___YES ___NO

WHILE IN RECOVERY, IS THERE LIGHT DUTY WORK YOU CAN REQUEST? ___YES ___NO

TO EVALUATE THE EFFECT THAT CONTINUING WORK WILL HAVE ON YOUR RECOVERY PELASE COMPLETE:

STANDING	☐	DRIVING	☐	OPERATE EQUIPMENT	☐	SITTING
TWISTING	☐	WORK W ARMS	☐	WALKING	☐	CRAWLING
LIFTING	☐	BENDING	☐	STOOPING	☐	OTHER_________________

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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PHYSICIAN'S LIEN

To: Attorney____

Re: Patient:________________________________ **Date of Accident:**___________

I hereby authorize the above doctor for furnish you, my attorney, with a full report of his examinations, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to **Multi Care Medical, LLC** such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due office and withhold such sums from any settlement, judgment or verdict as may be necessary adequately to pay said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds from any settlement, judgment or verdict which may be paid to you, my attorney or myself a result of the injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which may eventually recover said fee.

Dated:_______________ **Patient's Signature**_________________________________

Address ____

The undersigned being attorney of record for the above patient does hereby agree to

Observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above.

Dated:________________ **Attorney Signature:**__________________________________

Attorney, please sign and return to doctor's office as soon as possible. Keep one copy for your records.

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AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, patient in this office hereby authorize **Multi Care Medical, LLC** and/or the physicians of **Multi Care Medical, LLC** (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, LLC** and/or the physicians of **Multi Care Medical, LLC**.

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: _______

OFFICE USE ONLY

WITNESS: ____