PATIENT INFORMATION

Date:_____ Account Number:_____

Last Name:_____ Employer/School:_____

First:_____MI:_____ ü Full Time Student ü Part Time Student

Address:_____ Home Phone:_____

_____ Work Phone:_____Ext.:_____

City:_____ Date of Birth:_____SS#:_____

ST:_____Zip:_____Sex:_____ Marital Status: (S)ingle (M)arried (O)ther:_____

E-mail:_____

If patient is a minor or someone other than patient is responsible for payment, please complete the following:

Name:_____ Relation to Patient:_____

Address:_____ SS#:_____

City:_____ Employer:_____

ST:_____Zip:_____Sex:_____ Phone:_____Ext.:_____

Insurance #1: HEALTH W/C PIP MEDPAY OTHER Insurance #2: HEALTH W/C PIP MEDPAY OTHER

Name:_____ Name:_____

Address:_____ Address:_____

City, ST, Zip:_____ City, ST, Zip:_____

GRP/PLCY:_____ GRP/PLCY:_____

ID/CLM:_____ ID/CLM:_____

Insured:_____ Insured:_____

I authorize the release of general medical, as well as psychological/psychiatric or other information pertinent to my case, to any insurance company, adjuster, case manager, or attorney as may be necessary to process health insurance claims, or to facilitate collection of any balance due for services rendered. I understand that this authorization releases Omar Inaty, DC, PA from all legal liability that may arise from the release of the information.

Signature:_____ Witness:_____

Patient or Guardian

ASSIGNMENT OF BENEFITS/PROCEEDS AND CAUSES OF ACTION:

I hereby authorize and direct my insurance company and/or my attorney (Payor), to pay any medical and/or government benefits due to me to be made directly to Omar Inaty, DC, PA (Provider) for services rendered, both by reason of accident o illness, and by reason of any other bills that are due Provider. I direct Payor to withhold such sums from any disability benefits, medical payments benefits, No Fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf. This is to act as an assignment of my rights and benefits to the extent I am obligated to pay Provider for services rendered. In the event the payor of benefits above, obligated to make payments upon the charges made by Provider for their services, refuses to make such payments upon demand by me or Provider, I assign and transfer to Provider any an all causes of action that I might have or that might exist in my favor against such Payor and authorize Provider's name and further authorize Provider to compromise, settle or otherwise resolve said claim in any manner acceptable to Provider. I understand that I am and remain personally responsible for deductibles, co-payments, or any professional services not covered by my insurance company. If it becomes necessary to turn my account over for collection, I will be responsible for collection and/or attorney fees. I also understand that Provider may perform Social Security Traces or searches through a credit bureau or other available source to verify my name, social security number and/or mailing address.

Signature:_____ Witness:_____

Insured/Responsible Party

FOR OFFICE USE ONLY:

_____

_____

_____

DR. OMAR INATY, PA

PATIENT:_____DATE:_____ AGE:_____

HISTORY OF PRESENTING PROBLEM

1. Briefly describe how the accident/incident occurred?

_____
_____
_____
_____
_____

2. Did you have immediate pain/(pain site)

_____
_____
_____

DO NOT WRITE BELOW THIS LINE

3. List all of the physicians you have seen since this accident/incident:

_____
_____
_____
_____

4. List all of the tests that have been done since this accident/incident:

_____
_____
_____
_____

5. Check all current physical symptoms/problems:

___ HEADACHES
___ NAUSEA/VOMITING
___ BLURRED VISION
___ DOUBLE VISION
___ DIZZINESS
___ LIGHTHEADEDNESS
___ RINGING IN EARS
___ JAW PAIN
___ PAIN WHEN CHEWING
___ JAW POPPING
___ FLUID SENSATION IN EARS
___ DECREASED TASTE

___ DECREASED SENSE OF SMELL
___ NECK PAIN
___ SHOULDER PAIN
___ CHEST PAIN
___ ARM PAIN
___ HAND PAIN
___ UPPER BACK PAIN
___ LOW BACK PAIN
___ BUTTOCKS PAIN
___ LEG PAIN
___ FEET PAIN
___ HIP PAIN

___ PROBLEMS WITH MEMORY
___ EASILY DISTRACTED
___ CONCUSSION
___ CONFUSION
___ IRRITABLE
___ ANGRY OUTBURSTS
___ MOOD SWINGS
___ FATIGUE OR ALWAYS TIRED
___ TROUBLE UNDERSTANDING
___ FORGETFULNESS
___ FAINTING SPELLS
___ STARING SPELLS
___ LOSE TRACK IN CONVERSATIONS
___ GET LOST IN FAMILIAR PLACES
___ LOSES TRACK OF TIME

___ ATTENTION IS POOR
___ DISORIENTED
___ HALLUCINATIONS
___ POOR MOTIVATION
___ ANXIETY OR NERVOUSNESS
___ DAYTIME SLEEPING,
___ SLOWED REACTION TIME
___ SLURRED SPEECH
___ VIOLENT BEHAVIOR
___ INSOMNIA OR SLEEPING
___ PROBLEMS KEEPING UP WORK

___ DEPRESSION/SADNESS
___ LACK OF ENERGY
___ NIGHTMARES
___ THOUGHTS OF HURTING OTHERS
___ DECREASED SEX DRIVE
___ THOUGHTS ABOUT DYING
___ ANXIOUS/FEARFUL IN A CAR
___ FREQUENT THOUGHTS ABOUT THE ACCIDENT/INCIDENT

___ TEARFULNESS OR CRYING SPELLS
___ FLASHBACKS
___ THOUGHTS OF HURTING YOURSELF

___ WORRIES EXCESSIVELY
___ STARTLES EASILY

6. What are your current medications?_____
_____

7. Do you have any allergies? If yes, please list._____
_____

8. Do you have a history of ever having any of the following:

___ ASTHMA
___ MIGRAINES
___ DIABETES
___ HEART MURMUR
___ GLAUCOMA
___ TUBERCULOSIS
___ JAUNDICE
___ ULCERS
___ ABDOMINAL PAIN
___ KIDNEY DISEASE
___ VOMITING OF BLOOD
___ BLEEDING DISORDER
___ BLOOD IN URINE
___ IMMUNE DISIASE
___ HEART ATTACK
___ SEIZURES
___ THYROID OR ENDOCRINE PROBLEMS
___ HEART DISEASE
___ EYE DISEASE
___ RINGING IN THE FARS
___ LUNG DISEASE
___ HEPATITIS
___ CHRONIC CONSTIPATION
___ FREQUENT NAUSEA AND VOMITING
___ FREQUENT DIARRHEA
___ KIDNEY STONES/GAIL STONES
___ SICKLE CELL DISEASE
___ CANCER
___ STROKE
___ LIVER DISEASE
___ OTHER CONDITIONS NOT MENTIONED ABOVE:_____
_____

9. Do you smoke? I f so, how much?_____

10. Do you drink alcohol? If so, how much?_____

11. Do you use street drugs?_____

12. Please indicated if you have had any of the following, and give a brief description:

___ SURGERIES_____
_____

___ MOTOR VEHICLE ACCIDENTS_____
_____

___ WORK RELATED ACCIDENTS_____
_____

___ PREVIOUS SERIOUS INJURIES/ ILLNESSES_____
_____

SOCIAL HISTORY

1. Where were you working at the time of the accident?_____
_____

2. Were you out on medical leave? If so, how long?_____
_____

3. Have you changed employment since the accident?_____
_____

4. Who is your current employer?_____

5. What is your position?_____

6. How long have you been with this company?_____

7. Are you having any problems keeping up with your job due to this accident/incident?_____
_____

DAILY ROUTINE

arise at:_____
retire at:_____
work hours:_____
leisure activities:_____
any restrictions on cooking, cleaning, driving due to this accident/incident? Explain._____
_____

8. Date of birth:_____ Place of birth:_____

9. What is highest grade you completed in school?_____
_____

10. What is your marital status?_____

11. How many children do you have?_____
What are their ages?_____
What is the health status of your children?_____
_____

12. List your hobbies:_____

13. Is your mother living?_____ Her age_____
health status_____ State of Residence_____

14. Is your father living?_____ His age_____
health status_____ State of Residence_____

15. How many brothers and sisters do you have?_____
List their ages_____
Where do they live?_____
Are they in good health? If not, List any medical conditions._____
_____
_____

Dr Omar Inaty B.
Chiropractic Physician

Standard Disclosure and Acknowledgement Form
Personal Injury protection - Initial Treatment or Service Provided

The under signed insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have **explained** that services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bills is **properly completed** in all material provisions and ail relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

_____	_____	_____
Name (Print or Type)	Signature	Date

Licensed Medical Professional Rendering Treatment (Signature *by his* or *her own hand):*

_____	_____	_____
Name *(Print or Type)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(l)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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