

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:

- | | |
|--|---|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> DECREASED SENSE OF SMELL |
| <input type="checkbox"/> NAUSEA/VOMITING | <input type="checkbox"/> NECK PAIN |
| <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> SHOULDER PAIN |
| <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> CHEST PAIN |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> ARM PAIN |
| <input type="checkbox"/> LIGHTHEADEDNESS | <input type="checkbox"/> HAND PAIN |
| <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> UPPER BACK PAIN |
| <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> LOW BACK PAIN |
| <input type="checkbox"/> PAIN WHEN CHEWING | <input type="checkbox"/> BUTTOCKS PAIN |
| <input type="checkbox"/> JAW POPPING | <input type="checkbox"/> LEG PAIN |
| <input type="checkbox"/> FLUID SENSATION IN EARS | <input type="checkbox"/> FEET PAIN |
| <input type="checkbox"/> DECREASED TASTE | <input type="checkbox"/> HIP PAIN |
|
 | |
| <input type="checkbox"/> PROBLEMS WITH MEMORY | <input type="checkbox"/> ATTENTION IS POOR |
| <input type="checkbox"/> EASILY DISTRACTED | <input type="checkbox"/> DISORIENTED |
| <input type="checkbox"/> CONCUSSION | <input type="checkbox"/> HALLUCINATIONS |
| <input type="checkbox"/> CONFUSION | <input type="checkbox"/> POOR MOTIVATION |
| <input type="checkbox"/> IRRITABLE | <input type="checkbox"/> ANXIETY OR NERVOUSNESS |
| <input type="checkbox"/> ANGRY OUTBURSTS | <input type="checkbox"/> DAYTIME SLEEPING, |
| <input type="checkbox"/> MOOD SWINGS | <input type="checkbox"/> SLOWED REACTION TIME |
| <input type="checkbox"/> FATIGUE OR ALWAYS TIRED | <input type="checkbox"/> SLURRED SPEECH |
| <input type="checkbox"/> TROUBLE UNDERSTANDING | <input type="checkbox"/> VIOLENT BEHAVIOR |
| <input type="checkbox"/> FORGETFULNESS | <input type="checkbox"/> INSOMNIA OR SLEEPING |
| <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> PROBLEMS KEEPING UP WORK |
| <input type="checkbox"/> STARING SPELLS | |
| <input type="checkbox"/> LOSE TRACK IN CONVERSATIONS | |
| <input type="checkbox"/> GET LOST IN FAMILIAR PLACES | |
| <input type="checkbox"/> LOSES TRACK OF TIME | |
| <input type="checkbox"/> DEPRESSION/SADNESS | <input type="checkbox"/> TEARFULNESS OR CRYING SPELLS |
| <input type="checkbox"/> LACK OF ENERGY | <input type="checkbox"/> FLASHBACKS |
| <input type="checkbox"/> NIGHTMARES | <input type="checkbox"/> THOUGHTS OF HURTING YOURSELF |
| <input type="checkbox"/> THOUGHTS OF HURTING OTHERS | |
| <input type="checkbox"/> DECREASED SEX DRIVE | <input type="checkbox"/> WORRIES EXCESSIVELY |
| <input type="checkbox"/> THOUGHTS ABOUT DYING | <input type="checkbox"/> STARTLES EASILY |
| <input type="checkbox"/> ANXIOUS/FEARFUL IN A CAR | |
| <input type="checkbox"/> FREQUENT THOUGHTS ABOUT THE ACCIDENT/INCIDENT | |

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:

- | | |
|--|--|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> THYROID OR ENDOCRINE PROBLEMS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART DISEASE |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> EYE DISEASE |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RINGING IN THE EARS |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> LUNG DISEASE |
| <input type="checkbox"/> JAUNDICE | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> CHRONIC CONSTIPATION |
| <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> FREQUENT NAUSEA AND VOMITING |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> FREQUENT DIARRHEA |
| <input type="checkbox"/> VOMITING OF BLOOD | <input type="checkbox"/> KIDNEY STONES/GALL STONES |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> SICKLE CELL DISEASE |
| <input type="checkbox"/> BLOOD IN URINE | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> IMMUNE DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> OTHER CONDITIONS NOT MENTIONED ABOVE: _____ | |

9. Do you smoke? If 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 all 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.