

Total Health Concepts
Minicucci Chiropractic, P.C.
Dr. Kelly Minicucci

PATIENT INFORMATION

Date _____
Name _____
Address _____
City, State, Zip _____
Home Phone _____
Cell Phone _____
Age _____ Birth date _____
Single__ Married__ Divorced__ Widowed__
Domestic Partnership _____
Name of Spouse/Significant Other _____
Occupation _____
Place of Employment _____
How did you hear of Dr. Minicucci? _____

EMERGENCY INFORMATION

Name _____
Relationship _____
Home Phone _____
Work Phone _____
Cell Phone _____

PATIENT CONDITION

Reason for visit :

When did your symptoms begin? _____

Is this condition: getting worse staying the same

Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain) _____

TYPE of pain: (Circle all that apply)

Sharp Dull Throbbing Numbness Aching

Burning Tingling Cramps Stiffness Swelling

Shooting Other _____

How often do you have this pain? _____

Activities or movements that are painful to perform: (Circle)

Sitting Standing Walking Bending Lying Down

What treatment have you already received for your condition?

Have you had any broken/fractured bones? _____

If yes, where and when? _____

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TREATMENT AUTHORIZATION RECORD

Consent for Release of Information & Patient Notification Statement

I, _____, hereby authorize Dr. Minicucci and/or her employees, to release to employer groups, insurance companies, government agencies or other third party payers, and their agents, information concerning health care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility, available benefits and obtaining payment on the behalf, for the Chiropractic health care provided to me. This authorization may be revoked in writing at anytime, however, revocation will not apply to the previous dates of service. I understand that the care and service I will receive are subject to review by health care professionals, third party payors and review agencies.

I understand that I will be financially responsible for all charges incurred for my treatment if I revoke or refuse to authorize the disclosure of my medical records to a third party payor, and payment denial of my insurance claims results.

Patient/Guardian Signature _____

Date: _____

