Nardello Family Chiropractic
674 NE Jensen Beach Blvd.
Jensen Beach FL. 34957
(P) 772.334.0034
(F) 772.334.0032

Confidential Patient Information

Full name: _____ Jr./Sr
Last First M.I

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Primary Phone: _____H/M/B Alternate Phone: _____ H/M/B

Email Address: _____

Date of Birth: _____ Social Security No: _____ Gender: ☐ M ☐ F

Race: ☐ American Indian or Alaskan Native ☐ Asian Black or African American ☐ White

☐ Native Hawaiian or Pacific Islander ☐ Declined ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Declined ☐ Unknown Primary Language: _____

Occupation: _____ Employer: _____

Marital Status: ☐ S ☐ M ☐ D Name of Spouse: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Allergies to any meds? _____

Nardello Family Chiropractic
674 NE Jensen Beach Blvd.
Jensen Beach FL. 34957
(P) 772.334.0034
(F) 772.334.0032

Physician Information

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Phone: _____

Have you had previous chiropractic care? _____ When? _____

Primary Insurance: _____ Secondary: _____

Payment is expected at time of visit. Name of person responsible for payment if other than the patient:

_____

Health and accident insurance policies are an arrangement between the carrier and the patient, which are usually designed to offset a large portion of the total cost. This office will prepare any necessary reports and forms to assist in making collections from the insurance company to the patient. Any amount authorized to be paid directly to this office will be credited to the patient's account. It should be understood that all services furnished are charged directly to the patient who is personally responsible for payment.

I understand and agree that Dr. Thomas Nardello has the right to refuse to accept me as a patient at any time before treatments begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the history determines whether to accept me as a patient.

Date: _____ Signature: _____

How did you find us? _____

Chief Complaint Form

Nardello Family Chiropractic
674 NE Jensen Beach Blvd.
Jensen Beach FL. 34957
(P) 772.334.0034
(F) 772.334.0032

Patient: _____

Chief Complaint

Case Title: _____

Describe the reason for your visit: _____

_____

_____

When did your symptoms begin? (select one)

☐ Today ☐ This week ☐ Within last 3 months

☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: _____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe changes in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night

☐ It changes with the weather ☐ It does not change

What helps relieve your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) _____

What activities are limited by your discomfort? (select one or more)

☐ Bending	☐ Bowel Movements	☐ Coughing	☐ Daily Routine
☐ Driving	☐ Getting Up	☐ Lifting	☐ Lying Down
☐ Pulling	☐ Pushing	☐ Reading	☐ Sitting
☐ Sleeping	☐ Sneezing	☐ Standing	☐ Turning my head
☐ Urination	☐ Walking	☐ Working	☐ Other (please describe)

Where applicable, specify the approximate date of your most recent: (month/year)

Physical Exam: _____ Dental X-rays: _____

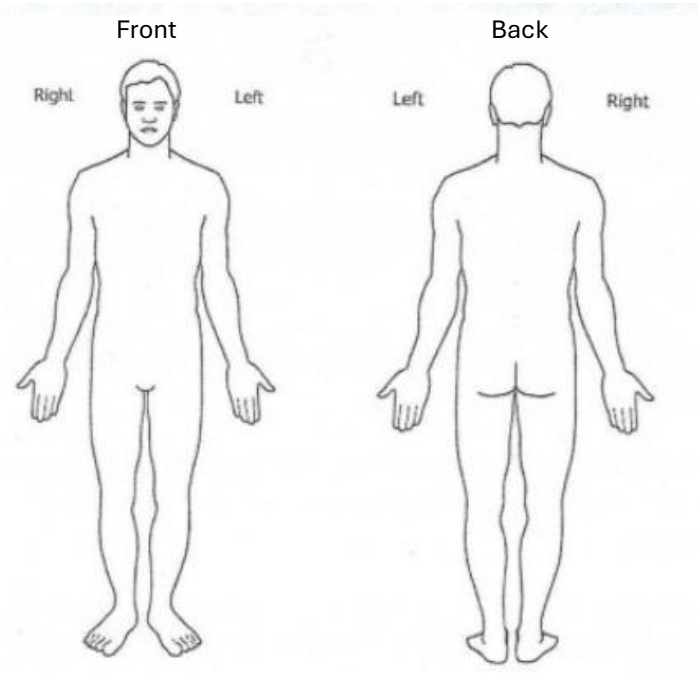
Spinal X-ray: _____ MRI: _____

CT Scan: _____ Other Scans or X-rays: _____

Nardello Family Chiropractic
674 NE Jensen Beach Blvd.
Jensen Beach FL. 34957
(P) 772.334.0034
(F) 772.334.0032

Patient Symptom Illustrator

Patient: _____



Instructions:

Identify your areas of discomfort by marking the affected body parts in the illustration.

Indicate the area name along with your specific symptoms associated with each selected area.

Rate your discomfort associated with each selected area.

		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness
										0 = No Discomfort 10 = Severe Discomfort
Ex.	L Ⓡ Lower Back			×			×			×
1.	L R									
2.	L R									
3.	L R									
4.	L R									

×

Nardello Family Chiropractic
674 NE Jensen Beach Blvd.
Jensen Beach FL. 34957
(P) 772.334.0034
(F) 772.334.0032

DISCLOSURE AND ACKNOWLEDGEMENT FORM

I hereby attest and affirm that:

1. The services set forth in the medical bills on this date were actually rendered.
2. I understand that I have the right and the affirmative duty to confirm that the services for which I am being billed for, or are being billed to my insurance carrier, have actually been rendered.
3. I was not solicited by any person to seek any services from the above named medical provider.
4. The physician, other licensed professional, clinic, or other medical institution rendering services, for which payment is being claimed, has explained the services rendered to me.
5. I understand that, if I notify the insurer in writing of a billing error, I may be entitled to a certain percentage of the reduction in the amounts paid by my motor vehicle insurer.
6. I understand that the physician, other licensed professional, clinic or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to me.

_____ _____

Signature of insured, patient or guardian Date

_____ _____

Signature of Licensed Medical Professional Date

Nardello Family Chiropractic
674 NE Jensen Beach Blvd.
Jensen Beach FL. 34957
(P) 772.334.0034
(F) 772.334.0032

Authorizations and Releases

Patient Name: _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Specific risks may be associated with chiropractic care such as soreness and soft tissue injury, which are not dangerous but should still be advised to the doctor. Rib injury, physical therapy burns, siroke, or other problems may occur in rare cases but treatment is rendered carefully to reduce these risks.

Initial _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initial _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initial_____

Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initial _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial _____

Financial Obligation

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company
receives the claim.
Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.
You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial _____

Signature _____ Date _____

Nardello Family Chiropractic
674 NE Jensen Beach Blvd.
Jensen Beach FL. 34957
(P) 772.334.0034
(F) 772.334.0032

Acknowledgement of Receipt of Notice of Privacy Practices

Nardello Family Chiropractic

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or have declined the opportunity to read them and understand the Notice of Privacy Practices. I understand this form will be placed in my patient chart and maintained for six years.

Patient Name (please print) _____ Date _____

Signature of Patient or Parent/Legal Guardian _____ Date _____

THIS FORM WILL BE PLACE IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.
List below the names and relationships of people to whom you authorize the Practice to release PHI.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____