Chiropractic Health Questionnaire

Name____ Home Phone___________________________

Address____ Apt #____ Cell Phone______________________

City________________________________ State _____ Zip ________ Email____________________________

Birth date_________________________ Age ______ Occupation ________________________________

Employer___________________________________ Marital Status: M W D S

Spouse Name_______________________________________ No. of Children ______

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name_______________________________
   ☐**Insurance Book** ☐ **Sign & Location** ☐ **Website** ☐ **Google ads** ☐ **BNI**
2. Primary Doctor ________________________ Primary Doctor Phone #: ________________________
3. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime?________________________ ☐ Never
4. When was your last complete spinal examination including x-rays?_____________ ☐ Never
5. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
   ☐ YES ☐ NO
6. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? ☐ YES ☐ NO
7. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? ☐ YES ☐ NO
8. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor - 1 2 3 4 5 6 7 8 9 10 – Excellent
9. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
   Low- 1 2 3 4 5 6 7 8 9 10 -High
10. Please list any health symptoms or health complaints you are experiencing.

    a. ___________________ b. ____________________ c. __________________ d. __________________

11. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

    ____

12. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?
    ☐ YES ☐ NO Date of Incident_______________________________
13. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? ☐ YES ☐NO
14. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations?☐ YES☐NO
15. Would you like to receive our monthly health and wellness newsletter via e-mail? ☐ YES ☐ NO

The above information is true and accurate to the best of my knowledge.

Patient Signature____ Date________________

ProHealth Chiropractic & Injury Center
19451 Sheridan St.
Pembroke Pines, FL 33332
Office: (954)842-2384 Fax: (954)589-0636
info@prohealthchirocenter.com

APPOINTMENT CALLS, OPEN ROOM ADJUSTING & HEALTH CARE

Dr. Cristian Hernandez, DC and the staff members of ProHealth Chiropractic & Injury Center may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released to or you may revoke your authorization to us at any time, however your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information, if they decide to contest any of your claims for services rendered.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. Your have the right to refuse to give us this authorization.

If you do not give us authorization, it will not affect the treatment we provide to you or the method we use to obtain reimbursement for your care. However, if necessary, information is not relayed to proper authorities, this might affect reimbursement.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack there of may be discussed at your office visits.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524).

This notice is effective on the day you commence treatment. This authorization will expire seven years after the date of your discharge but will be renewed on a yearly basis.

Patient Acknowledgement:

I, ______________________________________, authorize Dr. Cristian Hernandez to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form upon request.

PATIENT SIGNATURE: ____

PRINT PATIENT'S NAME: ____

DATE: ______________________________

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PATIENT'S NAME: ____ DATE:______________________

HEALTH INSURANCE QUESTIONNAIRE

Please check all that apply:

☐ 1. **I am** covered by my own HEALTH INSURANCE POLICY.

☐ 2. **I am** covered by SOMEONE ELSE'S HEALTH INSURANCE POLICY.
EXAMPLE: Spouse, Parent, Guardian, Dependent, Other, etc.

☐ 3. **I am NOT** covered by any HEALTH INSURANCE POLICY.

Health Insurance Company Name: ____

Identification and / or Policy #: ____

Insured's Name: _____________________________________ Relationship to Patient: ____________________

Insured's DOB: _____________________________________ Employer's Name: ________________________

AUTHORIZATION OF INSURANCE BENEFITS

I, ____, authorize my insurance company to make payment directly to Dr. Cristian Hernandez, ProHealth Chiropractic and Injury Center, 19451 Sheridan St. Pembroke Pines, FL 33332. In the event that the insurance company sends checks directly to me (the patient), I will be responsible to report to this office that I have received a check for services that were rendered by Dr. Cristian Hernandez, DC.

Patient Name: ____________________________________ Patient Signature: ______________________________

INSURANCE WAIVER

Your health insurance plan requires you to be financially responsible for co-payment, co-insurance and yearly deductibles for covered services as well as services provided that exceed your benefit limitations. Your are also financially responsible for all non-covered services, products (i.e., ice packs) and maintenance care.

Patient Acknowledgement:

I, ____________________________________, acknowledge that I have been told in advance by this office of all services and products that are not covered by my health insurance plan. In the event that my health insurance fails to pay for rendered services, I agree to pay for all services rendered, covered and non-covered services and products.

Patient Name: ____________________________________ Patient Signature: ______________________________

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TERMS OF ACCEPTANCE

The practice of chiropractic in this office consists of the following:

1. Analysis of the spine for the purpose of locating vertebral subluxations (spinal misalignments causing nerve interference).
2. Adjustments of the spine for the purpose of correcting vertebral subluxations.
3. *Education & Encouragement* of our patients / practice members to become aware of and responsible to their well-being.
4. Empowerment of our patients / practice members as to the inherent healing capabilities of the human body (Innate Intelligence).

Our intention is to **provide you** with **the best care** we can offer as outlined above.
We do not offer care with the intent of **'treating"** or **"curing"** diseases or conditions.

I, ___________________________________, understand the above information and wish to receive care from Dr. Cristian Hernandez for myself / my family, as outlined in this "Terms of Acceptance".

PRINT PATIENT'S NAME: ____

PATIENT SIGNATURE: ____

DATE: ______________________________

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RELEASE OF PATIENT RECORDS

DATE: ____________

I hereby authorize the release of my records/copies, any or all x-rays and request that they be faxed or transferred to the following provider:

To:

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Fax: (954)589-0636
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Patient's Name: ______________________________

Patient's Signature: ____________________________