2237 North Commerce Parkway, Ste 2
Weston, FL 33326
Phone 954-888-6650 ● Fax 954-888-6645
www.westonmedicalhealth.com

The Next Generation in Healthcare

CONFIDENTIAL PATIENT INFORMATION

Full Legal Name:_____/_____/_____
(Last Name) (First Name) (Middle Initial)

Preferred Name:_____Age:_____Date of Birth:_____ SSN: _____
(Full SSN Required Auto & Workers Comp otherwise last 4 digits)

Address:_____/_____/_____/_____
(Street Address) (city) (state) (zip code)

Telephone # (_____)_____ (_____)_____ (_____)_____
(Cell) (Home) (Work)

Email:_____Gender:____Race:_____Marital Status:_____

Emergency Contact Name & Number: _____

Occupation:_____ (Please Circle) FT/PT Student Retired

Employer / School Name and Address:_____

Name of Primary Care Physician:_____Contact Number:_____

How were you referred to our office? _____

What is your **Chief Complaint** or Reason for your visit today? _____

When did your injury?_____ Where did your injury/onset occur?_____
(Please Circle all that Apply) **WORK** **AUTO ACCIDENT** **HOME** **SLIP & FALL** **SPORTS** **INJURY**

Have your received treatment for your injury before? **YES** **NO** If yes, please specify: _____

Do you have Advance Directives? _____ If yes, provide copy at Front Desk:_____

Please list anyone you authorize Weston Medical Health Center to speak with ON YOUR BEHALF:_____
_____

HEALTH HISTORY

SOCIAL HISTORY:

Smoking: Do you Smoke Cigarette? **YES** **NO**
Alcohol: Do you consume Alcohol? **YES** **NO**
Drugs: Do you use any recreational drugs? **YES** **NO**
Exercise: Do you exercise? **YES** **NO**
Sports: Do you play sports? **YES** **NO**

MEDICAL HISTORY:

Pharmacy Name:_____

Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (zip code)

Consent to Obtain RX History: **YES** **NO**

Are you allergic to any medications?: **YES** **NO** If **YES,** Please list:_____

Please list any medications RX or over the counter are you taking now.

Medication Name	Strength	Dosage	Frequency/Take

Signature of Patient/Responsible Party_____**Today's Date**_____

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CURRENT HEALTH CONDITION

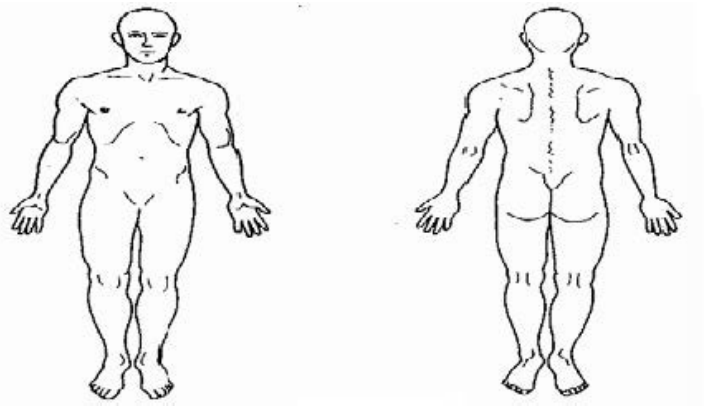
Do you currently, or have you ever had any of the following medical conditions?

Heart Disease	Yes	No	Heart Attack	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Stroke	Yes	No	Asthma	Yes	No
Hepatitis	Yes	No	Murmurs	Yes	No	Rheumatic Fever	Yes	No
Lung Disease	Yes	No	Bleeding Disorders	Yes	No	Anemia	Yes	No
Sickle Cell	Yes	No	Kidney Disease	Yes	No	Arthritis	Yes	No
Gout/pseudogout	Yes	No	Kidney Stones	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	GI Disease	Yes	No	Polio	Yes	No
Seizure disorder	Yes	No	Neuromuscular Disease	Yes	No	Psychological	Yes	No
Trauma	Yes	No	Blood clots or phlebitis	Yes	No	Blood Transfusion	Yes	No
HIV	Yes	No	Migraine	Yes	No	Osteoporosis	Yes	No
Other								
Please list all surgery and any periods of hospitalization (give dates)								

Where is your pain? **Indicate where you have pain or other symptoms with an X**

If your pain is a result of an auto accident or slip/fall, please indicate by circling where your body was struck

Arms:	Left	Right
Legs:	Left	Right
Knees:	Left	Right
Hips:	Left	Right
Shoulders:	Left	Right
Elbows:	Left	Right
Wrists:	Left	Right
Feet:	Left	Right
Head:	Left	Right
Neck:	Left	Right
Back:	Left	Right



From 0 – 10 where your pain is at its highest?

From 0 – 10 where is your pain at it's lowest?

How would you describe your pain? _____

What aggravates your pain? Please circle

Sit to Stand Walking Bending Squatting Walking Up Stairs Walking Down Stairs Laying Down Contact w/ Area

What Relieves your Pain? _____ _____

Is your pain worse in AM Or PM? _____

Do you have any recreational activities you are unable to perform at this time? _____

Signature of Patient/Responsible Party _____ **Today's Date** _____

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INSURANCE INFORMATION

Insurance Information – Please provide Insurance Card and State Driver's License at Front Desk

Insurance Co:_____ Member ID:_____ In

Insured's Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)
MVA: Date of MVA:_____ State MVA occurred:_____ Claim number:_____
Insurance Co:_____ Claim submitted □ Y □ N Adjuster:_____ Phone: (_____)_____

Attorney's Name:_____ Phone: (_____)_____ PIP Coverage:_____

Do you have any secondary or additional Insurance plans? □ Yes □ No Name:_____

ASSIGNMENT OF BENEFITS

I, the above/below-named patient, by signing below, hereby irrevocably assign to WESTONMEDICAL HEALTH CENTER, any and all of my rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined by Florida law, for any services and charges provided by WESTON MEDICAL HEALTH CENTER. It is the intent of the undersigned that this assignment is irrevocable and shall apply to any and all causes of action, lawsuits, claims, counter-claims, and demands. I understand that in the event it becomes necessary to collect monies owed through an attorney, I will be responsible for all costs including, but not limited to, attorney's fees and court costs. I also understand that this assignment of benefits gives WESTON MEDICAL HEALTH CENTER the right to file a lawsuit against my insurance company, or the applicable insurance company. By signing below, I certify I have read this assignment of benefits and I understand all of the terms and conditions. I acknowledge that all of my questions concerning this assignment of benefits have been fully explained to me by Weston Medical Health Center.

STATEMENT OF CONFIDENTIATLITY

I authorize payment of insurance benefits directly to the doctor or doctor's office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claims.

ADVANCED BENEFICIARY NOTICE (ABN) MEDICARE PATIENTS ONLY

You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit to our office. What you need to know:

- Read this notice, so you can make an informed decision about your care.
- Ask Questions.

__Yes, I want to receive these services.
__No I have decided not to receive these services.
__Other should I decide to request these services in the future, I understand I will be charged and am responsible for full payment.

For Chiropractic Services: Only Adjustments 98941. 98942, 98943 are covered.
All other services and/or supplies provided by Chiropractor will be an additional fee.

By Signing this notice you agree to take financial responsibility for the cost of the supplies and/or services listed above should your insurance company deny coverage for the listed items.

PATIENT RESPONSIBILITY

All co-pays are due at time of service.
Insurance companies provide providers **non guaranteed** information upon verification of benefits and may reimburse differently upon claim payment. You are responsible for deductibles, adjustments or unpaid balances made by your insurance. If your insurance company/plan overrides the assignment of benefits and makes claim payments directly to you, you are responsible to pay Weston Medical Health Center upon receipt. A payment arrangement for these services after an insurer has paid you is not acceptable. A copy of the Explanation of Benefits must accompany the check(s) so we may record your account properly. I authorize Weston Medical Health Center to retain my credit card on file for recurring billing, copays, deductibles and unpaid balances.

Signature of Patient/Responsible Party_____ **Today's Date**_____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Weston Medical Health Center. When you schedule an appointment with Weston Medical Health Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than **24 hours** prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective September 15, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment without 24 hour notice a **second** time will be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule without 24 hour notice should occur the patient may be **dismissed** from Weston Medical Health Center.
- Any patient who fails to show or cancels/reschedules a **Massage Appointment** without 24 hour notice will be considered a No Show and charged the **Full Amount** of the visit.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Weston Medical Health Center 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

Weston Medical Health Center (954)888-6650

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature of Patient/Responsible Party_____ **Today's Date** _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____DOB: _____

I hereby request and authorize you, your employees and agents to furnish all records and reports, including x-rays and photostatic copies and any other information relating to any examination, treatment or opinion concerning any condition that I may have had in the past or now have.

Other: _____

_____

_____ _____

Signature of Patient/Responsible Party Today's Date

Weston Medical Health Center (954)888-6650

Fax Records to: 954-888-6645

Requesting Records From:

Fax to Name:_____

Fax Number:_____

Telephone Number:_____