HAMPTON BAYS
CHIROPRACTIC & NUTRITION

PATIENT CASE HISTORY

Dear Patient,

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you!

Name _____ Date of Birth _____

Physical Address _____

Mailing Address _____

Phone Number _____ Alternative Phone _____

Email Address _____ Occupation _____

Marital Status M S W D Spouse's Name _____ Referred by _____

Emergency Contact _____ Relationship _____ Phone Number _____

HEALTH INFORMATION

Have you had previous chiropractic care? Yes/No If yes, where & when was last visit _____

What is your major complaint? _____

_____

Other complaints? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

How long has it been since you really felt good? _____

Other doctors who treated this condition _____

_____

List surgical operations and year _____

_____

Drugs you take now: ☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐"Pep" Pills ☐Tranquilizers
☐Insulin ☐Birth Control Pills ☐Others _____

What is the age of your mattress? _____ ☐ Comfortable ☐ Uncomfortable

Are your wearing: ☐ Heel lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

Have you been in an auto accident? ☐ Past Year ☐ Past 5 years ☐ Over 5 years ☐ Never

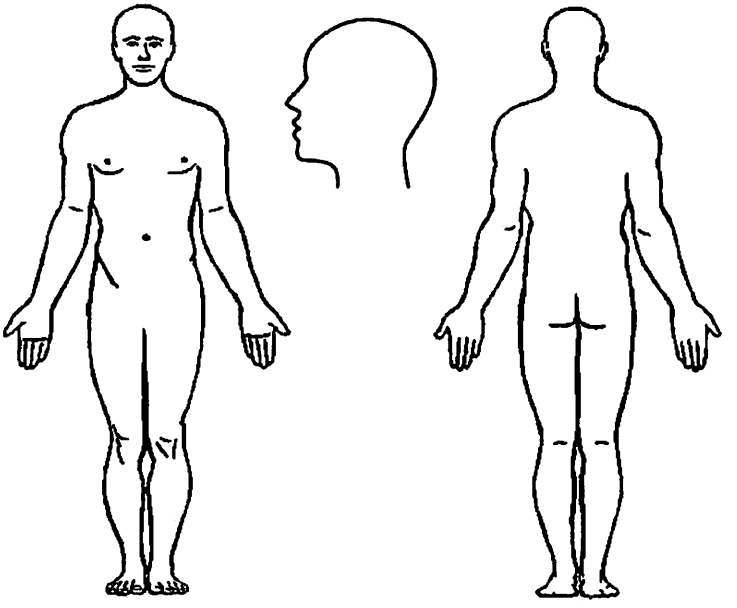
If yes, Describe _____

Have you had any personal injury/work accident? ☐ Past Year ☐ Past 5 years ☐ Over 5 years ☐ Never

If yes, Describe _____

When was your last physical exam with your primary care doctor? _____

Please mark your areas of pain on the figures below



Have you Ever Suffered From:

- ☐ Dizziness
- ☐ Backaches
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Arthritis
- ☐ Headaches
- ☐ Asthma
- ☐ Neuritis
- ☐ Digestive Disorders
- ☐ Nervousness
- ☐ Sinus Trouble
- ☐ Neck Pain

Insurance Information

Is your condition due to an auto accident or work related injury? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No

If yes, Primary Insurance Name _____ Policy # _____

Secondary Insurance Name_____ Policy # _____

Policy holder Name _____ Relationship_____ Date of Birth_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian's Signature_____ Date_____

Doctor's Signature _____

Stephany A. Meng D.C.
147 West Montauk Hwy
Hampton Bays, New York 11946

Gerard H. Piering D.C.
Telephone: 631.728.8545
Fax: 631.728.1242

Electronic Health Records Intake Form

First Name: _____ Last Name: _____ DOB: _____

Email Address: _____

Phone #: _____ Gender: ☐Male ☐Female Preferred Language: _____

Preferred method of communication for patient reminders: ☐Email ☐Phone ☐Mail

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Pacific Islander ☐White (Caucasian) ☐I decline to answer

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐I decline to answer

Smoking History: ☐Every Day Smoker ☐Occasional Smoker ☐Former Smoker ☐Never Smoked

Smoking Started Date (Optional): _____

Family Medical History

(Many health problems are the result of hereditary spinal weaknesses; this information about your family members will give us a better picture of your total health picture)

Name	Relationship	Past and Present Health Problems

Current Medications

Please list all medications, including any regularly used over the counter medications, along with the dosage and frequency.

_____

_____

_____

Allergy to Medications? ☐Yes ☐No *If yes, please list the medication below and the reaction that occurs below*

_____

_____

Patient Signature: _____ Date: _____

For Office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____ HR: _____

Stephany A. Meng D.C.
147 West Montauk Hwy
Hampton Bays, New York 11946

Gerard H. Piering D.C.
Telephone: 631.728.8545
Fax: 631.728.1242

Acknowledgement of Receipt of Privacy Notice

I,_____, have been presented with a copy of Hampton Bays Chiropractic's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under Federal and State law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature of Patient: _____ Date:_____

Relationship: _____ Witnessed By: _____

If not signed by patient, please indicate relationship to patient (ex. Parent/Guardian)

Internal Use Only:

If patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

HEALTH INSURANCE CLAIM FORM

Only sign your name on the "X"

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.