Bruce M. Fischer, DC CCSP

Belle Terre of Boca Raton 851 Meadows Road, Suite 213, Boca Raton, FL 33486

PH: 561.392.1333 Fax: 561.392.9707 www.bocatrauma.com

Confidential Patient History

Name: _____ Date of Birth: _____

Address: _____City: _____State:_____Zip:_____

Phone (home):_____Cell:_____Work:_____

Occupation: _____Employer:_____Student (yes) (no)

Marital Status: M- S- D- Wid Email: _____

Whom may we thank for referring you to us? _____

Request/ Confirm appointment: Online_____Email_____Text Message_____

Social Security Number (Confidential): _____

What is your chief complaint? _____

Emergency Contact Person? _____Phone_____Relationship_____

Name of Primary Care Physician: _____

Please list current medications: _____

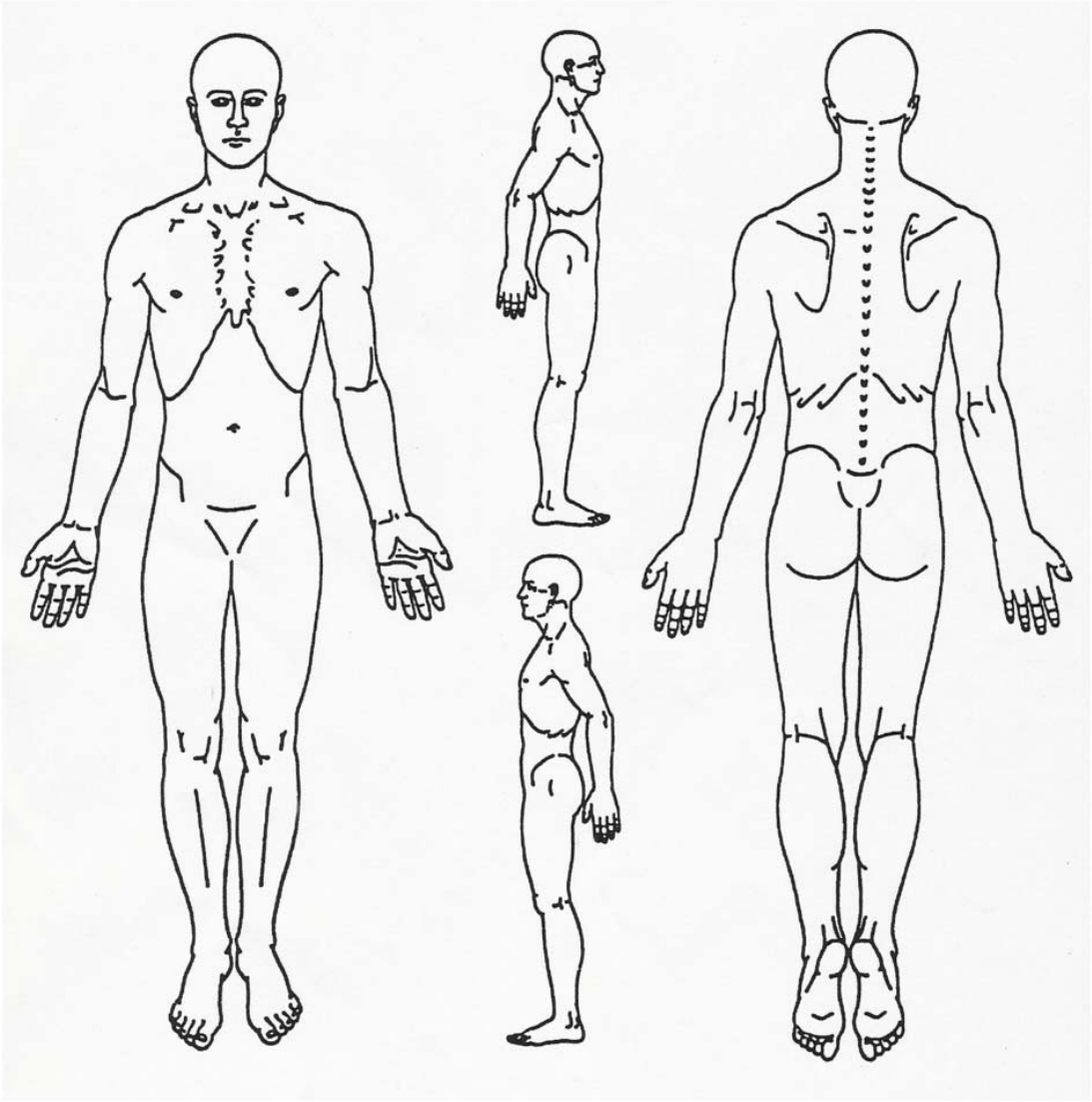
I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Bruce M. Fischer, DC PA or Boca Trauma and Rehab will prepare any necessary reports or forms to assist me in making collection from my insurance carrier and that any amounts authorized to be paid directly to this 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 I am personally responsible for payment.

Patient's Signature _____ Date_____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

NAME: (please print)_____

How long have you experienced neck/back pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back pain? _____ YES _____ NO

SIGNATURE:_____ DATE:_____

KLD 01/06

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____
		Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

_____

Bruce M. Fischer, D.C., P.A.
CHIROPRACTIC PHYSICIAN

851 Meadows Road, Suite 213, Boca Raton, Florida 33486
Telephone: 561.392.1333 Fax: 561.392.9707 www.bocatrauma.com

ASSIGNMENT OF BENEFITS

I, (first/last name)_____ HEREBY AUTHORIZE_____
TO MAKE MEDICAL BENEFITS PAYMENTS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED BY BRUCE M. FISCHER DC PA OR BOCA TRAUMA & REHAB BUT NOT TO EXCEED THE CHARGES OF THOSE SERVICES PAYABLE TO AND MAILED DIRECTLY TO BRUCE M FISCHER DC PA OR BOCA TRAUMA & REHAB, 851 MEADOWS RD. SUITE 213, BOCA RATON FL 33486. FURTHERMORE, I IRREVOCABLY ASSIGN TO BRUCE M FISCHER DC PAOR BOCA TRAUMA & REHAB THE RIGHTS AND BENEFITS UNDER ANY POLICY OF INSURANCE, INDEMNITY AGREEMENT OR ANY OTHER COLLATERAL SOURCE AS DEFINED IN FLORIDA STATUTES FOR ANY SERVICE AND OR CHARGES PROVIDED BY BRUCE M FISCHER DC PA OR BOCA TRAUMA & REHAB

IN WITNESS THEREOF, THE UNDERSIGNED HAS/HAVE EXECUTED THIS ASSIGNMENT OF BENEFITS _____ DAY OF _____

_____ _____
PATIENT'S NAME PATIENT'S SIGNATURE

Health Insurance Portability & Accountability Act – Information required by the Federal Government for Medical patients.

Provider Notice of Information Practices

Uses and Disclosures of Health Information

We use health information about you for treatment (diagnostic testing, referral), to obtain payment (submit claims and/or encounters to billing services and/or clearinghouses, collection agencies, only if necessary), for administrative purpose (reporting utilization management, quality improvement). We may disclose health information about you without your authorization in emergencies, such as Emergency Room situations, and if required by law enforcement. In any other situation, we will contact you and ask for written authorization before disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may apply a change to our policies at any time. Before we make a change in our policies, we will post a notice in the waiting room. You may request a copy of our notice at any time and contact our office for further information on our privacy practices.

Individual rights

You have the right to obtain a copy of your reports for your records. There may be a charge for this. You have the right to receive a list of written instances in which we have disclosed protected health information about you for reasons other than treatment, payment or other related administrative purposes. If you believe that information in your record is incorrect or incomplete, you have the right to request in writing that we amend the existing information. You may request in writing that we restrict and/or not use or disclose your information for payment and administrative purposes, except when specifically authorized by you. When required by law or in emergency situations. We will consider your request, but are not legally required to agree to it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, please contact our office or direct inquiries to:

Privacy Manager
Boca Trauma & Rehab
851 Meadows Rd. Suite 213
Boca Raton, FL 33486
(561) 392-1333

You may send a written complaint to the U.S. Department of Health and Human Services, call our office for the address.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices as described in this notice.

I have reviewed the above information.

Patient Signature_____ **Date** __/_____

Bruce M. Fischer, DC CCSP
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MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT: _____

DATE OF BIRTH: _____

PATIENT ID (SSN): _____

TO: _____

This is your authority to release any and all records, x-rays, and medical information to Boca Trauma and Rehab, Bruce M. Fischer, DC.

RECORDS REQUESTED:

MEDICAL RECORDS: _____

X-RAYS/MRI FILMS: _____

LABS/EKG: _____

_____

PATIENT or PARENT (if minor) signature

_____

DATE

Disclosure & Consent for Chiropractic Adjustments and Medical Care

To the Patient: You have a right to be informed about your condition and the recommended chiropractic adjustments and the other physical and medical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks hazards inherent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other medical procedures, including various modes of physical therapy, which includes heat, ice, electric muscle stimulation, ultrasound, therapeutic exercises, taping, laser therapy, massage therapy, diagnostic x-rays, injections and prescription medication on me or (the patient named below whom I am legally responsible for) by the Chiropractic Doctor of Chiropractic, Physical Therapist and Medical Doctor.

I have had the opportunity to discuss with Dr Bruce Fischer and /or Dr Naveed Shafi and/or Tamar Clarke RPT, my diagnosis, the nature and purpose of the Chiropractic adjustments, physical therapy, medical procedures and other therapy listed above as well as the risks and benefits of my chiropractic treatment, medical treatment and physical therapy and the risks and benefits of alternative treatment, including not treatment at all.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including but not limited to:

___Fracture ___Disc or Spinal injuries ___Stroke ___Dislocations ___Sprains/Strains ___Possible increase symptoms or pain ___No improvement of symptoms or pain ___ Other_____

I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based on the facts known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

TREATMENT PLAN:
_____
_____
_____
_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print Name

_____
Signature of Patient

_____
Date Signed

To be completed by the patient's representatives:

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

as: _____
Relationship/authority of Patient's Representative

Date _____