Our office staff will assist you in utilizing insurance benefits when all necessary information is completed, signed and dated. When accepting assignment, the doctors are granting you credit for the portion we expect your insurance company to pay.

THANK YOU FOR CHOOSING US AS YOUR HEALTH PROVIDER

Personal **Guarantor (Insurance)**

Patient Name_____

Address _____

City/State/Zip_____

Social Security #_____

Gender (M) (F) Marital Status S M D W

Patient's Birthday____/____/____

Home Phone_____

Work Phone_____

Cell Phone_____

E-Mail_____@_____

Spouse's Name_____

Send Statements to: ☐ Patient

Or _____

Address_____

City/State/Zip_____

Who referred you to our office?_____

_____

Have you seen any other practitioner for this condition?

If yes, whom?_____

MD? Chiropractor? Massage? Acupuncture? Other?

May we send your Primary Care Physician a report on your condition? ☐ Yes ☐ No

If yes, Name_____

Case

Were you in an auto accident? YES NO Date_____

Were you injured on the job? YES NO Date_____

If you answered yes to either question, please notify the front desk NOW.

If yes, do you have an attorney? YES NO

Name_____

There will be no charged services without your informed consent.

Policy Holder_____

Address_____

City/State/Zip_____

Social Security #_____

Gender (M) (F) Birthday____/____/____

Insurance Company_____

_____**YES Insurance Card Copied**

Patient ID #_____

Group #_____

Patient or Guardian, Please initial:

_____ **YES I will pay my portion at time of service**

_____ **YES This office has my permission to copy my Driver's license or photo ID for the purposes of verification and identification only.**

_____ **YES I have read and understand the "advised Consent" form.**

AUTHORIZATION AND ASSIGNMENT OF BENEFIT

I authorize the staff of Dr. La Ruffa to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any medical information necessary to process and pay this claim. I authorize payment of the health benefits, "Medical Reimbursement," and/or "Government Benefits" otherwise payable to me to be paid directly to:

August J. La Ruffa III, DC

I understand this office only accepts assignment when Insurance pays directly to us.

►_____ ____/____/____

Patient/Guarantor's Signature Date

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's signature:_____ Date_____

Parent or Guardian Name (Please Print): _____

Parent or Guardian Signature:_____ Date_____

Present Complaints (please circle the appropriate ones)

Headache	Ankle Pain	Blurred vision	Tension
Neck Pain	Lower back pain	Fainting	Hip Pain
Shoulder Pain	Pins and needles in arms	Unbalanced	Foot Pain
Elbow Pain	Pins and needles in hands	Dizzy	Nervousness
Wrist Pain	Pins and needles in legs	Eye strain/pain	Double vision
Upper back pain	Chest pain	Shortness of breath	Constipation
Mid-back pain	Rib pain	Allergies	Irritability
Mid-back stiffness	Ears ringing/buzzing	Depression	
Knee Pain	Feet/hands cold	Loss of memory	

When did your symptoms start?_____
How did your symptoms start?_____

How would you describe your pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness

☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness

Please rate the intensity of your pain (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Moderate pain) (Severe pain)

How often is the pain present?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

Is your pain? ☐ Getting Worse ☐ Getting Better ☐ About the same ☐ On and off

What makes your problem better?

☐ Nothing ☐ Walking ☐ Sitting ☐ Moving/exercise ☐ Lying down ☐ Medication_____

What makes your problem worse?

☐ Nothing ☐ Walking ☐ Sitting ☐ Moving/exercise ☐ Lying down

Do you exercise? ☐ Yes ☐ No **If yes, what type?**_____ **How often?**_____

Has the problem interrupted your sleep? ☐ Yes ☐ No **If yes, how?**_____

Does anyone in your family have the same or similar condition: ☐ Yes ☐ No

If yes, who?_____

List any operations that you've had and approximate dates: _____

_____

Are you taking any Vitamins/Nutritional Supplements? Please list: _____

_____

Are you taking any medications? Please list: _____

_____

Are you allergic to any medication? Please list: _____

Do you wear Orthotics (shoe inserts)? ☐ Yes ☐ No **If yes, what type?** _____

Are you pregnant? ☐ Yes ☐ No **If yes, Due date:** _____

Date of last Menstrual Period_____

Do you: **Smoke:** ☐ Yes ☐ No **Amount per day:** _____

Drink: ☐ Yes ☐ No ☐ Light ☐ Medium ☐ Heavy

Patient Name: _____ **Date:** _____