Premier Urgent Care
Badolato Family Health

Patient Information

How did you hear about us? ☐Website ☐ Friend/Family ☐ Phone Book ☐Other _____

Last Name: _____ **First Name:** _____ **Middle Initial:** ____

Age: _____ **DOB:** _____ **M F SS#:**_____ **Email:**_____

Marital Status: _____ **Person Responsible for account:** _____

Address: _____

Permanent (If P.O. Box please provide street address also)

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **EXT**____ **Cell:** _____

***Temporary Address*:** _____

City: _____ **State:** _____ **Zip:** _____ **Temporary Phone:** _____

Emergency Contact _____ **Phone#** _____ **Relationship** _____

Family Doctor/Internist: _____ **Phone#** _____

Employer: _____ **Phone:** _____ **EXT**_____

Employer's Address: _____ **Years with Employer:** _____

Spouse's Name: _____ **Date of Birth:** _____ **Spouse's SS#:** _____

Spouse's Employer: _____ **Employer Phone#:** _____

If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges. Please be advised that it is *your responsibility* to be aware of the benefits that your medical plan provides.

PRIMARY INSURANCE COMPANY

Company: _____

Policy#: _____

Group#: _____

Policy Holder: _____

Policy Holder DOB: _____

Phone#: _____

SECONDARY INSURANCE COMPANY

Company: _____

Policy#: _____

Group#: _____

Policy Holder: _____

Policy Holder DOB: _____

Phone#: _____

****Please indicate the lab your insurance co. uses: ___Quest ___Lab One ___Labcorp ___Wuesthoff ___Health First**
I understand that if my choice for *LAB DIRECTIVE is incorrect, I am financially responsible for the bill that the lab sends me. If no Lab chosen we will send to Quest Laboratory automatically.

I, _____ hereby assign all medical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance, and any other health plans to **D. Badolato P.A./Premier Urgent Care of Brevard, LLC**. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize release to my insurance carrier, employer, and referring physician any information needed including diagnosis and records of any treatment or examination rendered to me to process this claim. Lifetime signature authorization. This authorization and assignment are to be continuing, remaining in force until revoked in writing by the undersigned for services beginning:

Patient/Guardian Signature: _____ Date: _____

Premier Urgent Care

INITIAL HEALTH STATUS

PATIENT MEDICAL HISTORY

Name:_____ **Age**: _____ **Birthday**: _____

Are you presently working? ☐ Yes ☐ No; If Yes ☐ Light/Moderate duty ☐ Regular duty

Are you ☐ Right ☐ Left handed?

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headaches ☐ TMJ ☐ Neck ☐ Upper back ☐ Shoulders ☐ Low back ☐ Arm ☐ Leg
☐ Elbow ☐ Wrist ☐ Hand ☐ Finger ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Toe
Other: _____

How did this problem begin? ☐ Lifting ☐ Twisting ☐ Falling ☐ Crushing ☐ Motor Vehicle accident ☐ Unknown
Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began:_____

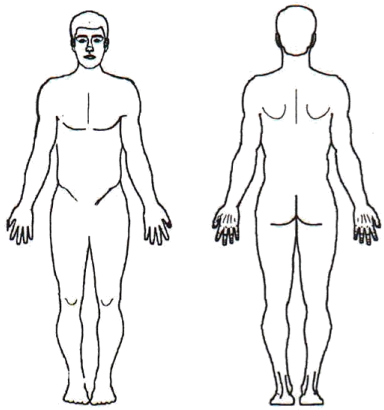
How Problem Began:_____

Current Complaint (How you feel today):

|_____|

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable Pain**



(Mark areas of discomfort)

How often are your symptoms present?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, household chores?)

|_____|

No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry on any activities

In general, would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are you currently being seen by any of the following?

☐ Medical Doctor ☐ Psychiatrist/Psychologist ☐ Physical/occupational Therapist ☐ Osteopath ☐ Chiropractor

Have you been hospitalized for this problem? ☐ Yes ☐ No If Yes, Dates: _____

Have you had Spinal X-RAYS, MRI, CT Scan for your areas of complaint? ☐ No ☐ Yes

Dates Taken: _____ What areas were taken?_____

Please list any surgeries (In/Out patient) and any other conditions for which you have been hospitalized:

Date	**Reason**	**Date**	**Reason**	**Date**	**Reason**
_____		_____		_____	
_____		_____		_____	

Have you ever had a fracture or dislocation? ☐ Yes ☐ No

If yes, which body part(s)? _____ Date:_____

Are you pregnant? ☐ Yes ☐ No **If yes # Weeks:**_____

Do you have any of the following metals or plastics in your body?

☐ Rods ☐ Pins ☐ Plates ☐ Staples ☐ Artificial joints ☐ Metal from gunshot wound ☐ None.

If checked any of the following, which location(s)? _____

List current medication: _____

_____

List current supplements: _____

_____

Turn Over →

Please check all the apply to you:

- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Alcohol/Chemical/Drug Dependency
- ☐ Arthritic Conditions
- ☐ Cancer/Tumor (Explain)_____
  _____
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Elevated Cholesterol
- ☐ Epilepsy/Seizures
- ☐ GI Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Marked Morning Pain/Stiffness
- ☐ Menstrual Problems
- ☐ Numbness in Groin/Buttocks
- ☐ Osteoporosis
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Prostate Problems
- ☐ Recent Fever
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Stroke (Date)_____
- ☐ Taking Birth Control Pills
- ☐ Tobacco Use — Type _____
  Frequency_____/Day
- ☐ Tuberculosis
- ☐ Urinary Problems
- ☐ Visual Disturbance
- ☐ Other Health Problems:_____
  _____

Family History:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I recertify to the best of knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health care plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ **Date**: _____

Reviewed By:_____ **Date**:_____

Premier Urgent Care
Badolato Family Health at Suntree / Viera

David W. Badolato, MD Stephen K. Badolato, MD Yvette Lopez-Granberry, MD Frank J. Listello, MD Brad A. Nelson, DC
Christopher Galloway, MD Dan Berk, MD Kenneth Rice, PA-C Sarajane Sengel, PA-C Walter, Joyner, PA-C

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and my follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Obtain payment from third party payers.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Private Practices.*

Patient Name: _____

Name of Personal authorized to receive information on patient's medical record:
___Self (Only)
___Other _____ Relationship to Patient:_____

Signature: _____
I also understand Florida Law requires specific authorization regarding the release of any super confidential protected health information (specifically any protected health information regarding HIV/ AIDS, Mental Health, Substance Abuse or Reportable STD's). I give my authorization to this organization to release any super confidential protected health information to:

- Conduct, plan and direct my treatment and my follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Person(s) listed above as authorized to receive information on my behalf.

Patient Name: _____

Signature: _____ **Date:** _____
Relationship to Patient: ___Self ___Parent/Guardian ___Other _____

6300 N Wickham Rd, Suite 101 Melbourne, Fl 32940

Office: (321) 253-2169 **Fax: (321) 253-1720**

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Patient Informed Consent

All health professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/ or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic.

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Chiropractic care does not diagnose internal or medical conditions. Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can result in disruption of the biomechanical and neurophysiological dynamics of the continuous spinal and paraspinal structures. This can cause a Vertebral Subluxation Complex, which can then interrupt the body's inherent ability to express its maximum health potential.

The practice of chiropractic care can include exams, diagnostic testing, radiological testing, physical therapy and rehabilitation procedures and chiropractic manipulative therapy (chiropractic adjustments). Adjustments are made by Chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. There are many different adjusting techniques, some using specialized equipment. An adjustment is the application of a specific movement over a specific segmental contact point to reduce or stabilize a subluxation.

I have had an opportunity to discuss with the doctor of chiropractic and/or with office personnel, the nature of chiropractic adjustments and other procedures and I understand that the results are not guaranteed. I further understand and am informed that, as in all health care, there are some very slight risks of treatment, which may include musculoskeletal sprain/strain, disc injuries, dislocations, stroke, etc. 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 then known, and is my best interest.

I have read the above consent. I have also had the opportunity to ask questions about the consent and by signing below I agree to the above named procedures. 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.

Print Name	Signature of Patient or Guardian
Date	Witness