Dr. Jerry Sangiamo

Family Chiropractic & Massage Therapy

43 Marchwood Rd., Suite 1. Marchwood Center. Exton, PA 19341 ♦
610 594-2552 office ♦ 610 594-2559 Fax ♦

Confidential Patient Health Questionnaire

Date:_____ ❒ M ❒ F Chiropractor: Dr. Sangiamo

Name:_____ Soc. Sec. # _____

Address: _____ City: _____ St.____ Zip_____

Home Phone:_____ Cell Phone: _____

Email: _____ Age: ____ D/O/B:_____ Status: S M D W # Children_____

Would you like to receive email appointment reminders and office notices from our practice? Y N

Would you like to receive text appointment reminders? Y N If yes, please indicate cell carrier_____

Occupation: _____ Employer: _____

Spouse: _____ Nearest Relative: _____ Phone: _____

How did you hear about our office? ❒ Yellow Pages/Book ❒ Internet ❒ Office Sign ❒ Friend/ Neighbor ❒ Dr.

Please give referral's name so we may thank them. _____

Reason for seeking care:_____

Date symptoms first appeared: _____

How did it occur? _____

_____

Have you ever had similar symptoms: ❒ Yes ❒ No If so Describe: _____

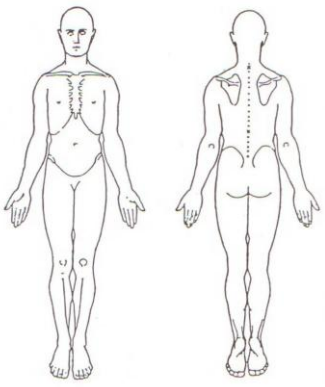
_____

Has the pain increased recently: ❒ Yes ❒ No ❒ Same ❒ Gradual worsening ❒ Better ❒ Other

How often does it hurt? ❒ Constant ❒ Daily ❒ Intermittent ❒ Only at night ❒ Other _____

Describe the pain: ❒ Achy ❒ Dull ❒ Sharp ❒ Stabbing ❒ Electric shock ❒ Tingling ❒ Numbness

On a scale from 0-10 rate your pain today 0= none 10= Worst pain. 0 1 2 3 4 5 6 7 8 9 10



In the diagram to the left please indicate areas of pain with an "X"

Is there anything that relieves the pain? ❒ Yes ❒ No Describe: _____

_____

What makes the pain worse? _____
❒ Standing ❒ Sitting ❒ Lying down ❒ Bending ❒ Lifting ❒ Twisting

Other: _____

_____

Has it affected your daily activities? ❒ Yes ❒ No

Do you Smoke? ❒ Yes ❒ No Do you drink? ❒ Yes ❒ No ❒ Occasionally ❒ Socially ❒ Frequently

Work Status: ❒ Full time ❒ Part time ❒ Unemployed ❒ Light Duty ❒ Retired ❒ Homemaker ❒ Student

Primary Care Physician: _____Office Location: _____

Date of last physical exam: _____ What surgeries have you had, with dates:_____

_____

Serious Illnesses: _____

Have you been treated for any health conditions by a physician in the last year? ❒ Yes ❒ No

If so describe: _____

Have you broken any bones? ❒ Yes ❒ No _____

What medications are you taking: _____

Are you allergic to any medications? ❒ Yes ❒ No _____

Do you suffer from any allergies? ❒ Yes ❒ No ❒ Seasonal _____

To your knowledge, have you had any disease, major illnesses or other important health history not indicated on this form either in past or present? ❒ Yes ❒ No Explain:_____

_____

Women only: Are you pregnant or is there any possibility you may be pregnant? ❒ Yes ❒ No ❒ Uncertain

Date of last menstrual period: _____ ❒ Post menopausal ❒ Peri menopausal ❒ Other _____

Please check any and all Insurance coverage that may be applicable in this case:

❒ B/C B/S ❒ Personal Choice ❒ Aetna ❒ Keystone ❒ Cigna ❒ Medicare ❒ Supplemental ❒ Other _____

Do you have a Health Savings Account / Flex Spending Account ❒ Yes ❒ No

Name of Primary Ins. _____ Policy #: _____

Name of Secondary Ins. _____ Policy #: _____

Case Manager, if any: _____ Claim #: _____

Authorization and Release: I authorize payment of insurance benefits directly to Dr. Jerry Sangiamo.
I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic 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 understand that a service fee will be charged to overdue accounts.

Patient Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

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HIPAA
HEALTHCARE AUTHORIZATION FORM

Patient Name: _____

Patient Soc. Sec. #: _____

Date of Birth: _____

Specific Authorizations

In this document, "I" and "my" refer to the patient and "chiropractor" refers to Dr. Jerry Sangiamo.

I hereby authorize Dr. Jerry Sangiamo to use my address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, greeting cards, testimonial book, referral book, website, information about treatment alternatives or other health related information.

If Dr. Sangiamo contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

By signing this form you are giving Dr. Sangiamo permission to use and disclose your protected health information in accordance with the directives listed above.

I understand I have the right to revoke this authorization, in writing at any time by sending such written notification to the Privacy Officer (Debbie Felker), at Family Chiropractic and Massage Therapy, 43 Marchwood Rd, Suite 1, Exton, PA 19341.

I understand that a revocation is not effective to the extent that Chiropractor has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature: _____

Date: _____