Dr. David N. Block Family Chiropractor
Dr. Mindal R. Donner Family Chiropractor
Patient Information

Name(First, Middle, Last)_____Date_____

Address(no PO boxes)_____City_____State_____Zip_____

Home phone_____Work phone_____ Cell phone_____

How do you prefer your electronic appointment reminder, email or text? _____

For text reminders, please list your cell phone carrier (AT&T, Verizon, T-Mobile, Sprint, etc) _____

Social Security # _____ E-mail address_____

Age _____Birthdate _____/_____/_____ Sex M / F Status M S W D No.Children_____

Occupation _____Employer _____Years Employed_____

Work Address_____City_____State_____ Zip_____

Spouse's Name_____Occupation_____ Employer _____ S.S.#_____

Primary Insurance Plan Name_____ID#_____Group#_____

Policy Holder's Name_____Relationship to policy holder:Spouse___Child___Self___

Policy Holder's Birthdate _____

Secondary Insurance Plan Name _____ ID# _____ Group #_____

Is your condition due to an auto accident? Yes____No____ If yes, what state? _____

Is your condition work related?Yes__No__ Is your condition related to another accident? Yes__No__

What is your deductible_____ Was it met? Yes ____ No ____ Unsure ____

If no, it will be paid by Cash_____ Check_____ Credit Card_____ Other_____

Immediate Family under care in this clinic_____

I understand that the above patient is a minor and I personally guarantee payment for all charges related to:

*(patient name)*_____*Name of guarantor:* _____

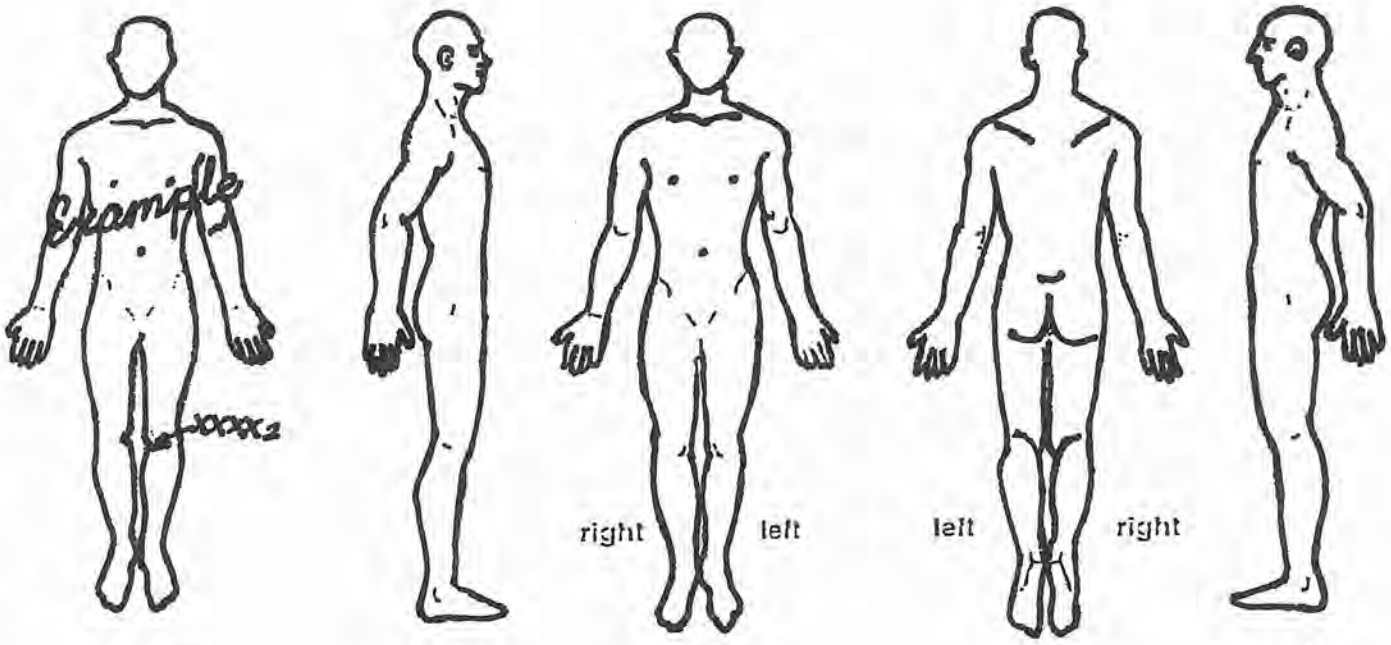
*Signature of guarantor:*_____*Date:*_____With

my signature below, I authorize the assignment of insurance benefits directly to Dr. David N. Block.

Patient/Guarantor Signature: _____Date:_____

Show Us Where It Hurts:

In the diagram below, please draw an arrow pointing to the area(s) of your pain or condition:



Authorization for Care, Insurance Assignment & Fees Please read and sign

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that Dr. David N. Block Family Chiropractic will prepare any necessary documents to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. David N. Block, Inc. will be credited to my account on receipt (insurance assignment of benefits). However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment as well as collection manager/attorney's fees of 33.3% and any and all related costs of collection, including filing fees, should such action become necessary. Interest rate on unpaid balances is the greater of 1.65% per month or $5.00 per month and begins from the time an account has been considered delinquent. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I also authorize the doctor to bill any unpaid balance to my credit card if it was used previously in the office to pay for services rendered, to obtain a credit report if deemed necessary and verify my employment should that information be needed in the collection of unpaid balances.

I hereby authorize the doctor to provide for me manual adjustments to my spine and therapy. The patient also agrees that he/she is responsible for all bills incurred at this office including interest on unpaid balances. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

Patient Name_____ Date_____

Patient Signature _____ Date_____

Guardian/Spouse/or Guarantor's Name Authorizing Care_____Date:_____

Guardian/Spouse/or Guarantor's Signature Authorizing Care_____Date:_____

General Health History

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OVER THE PAST 6 MONTHS

General Symptoms
- ☐ Headaches/Migraines
- ☐ Allergies
- ☐ Sleeping Problems
- ☐ Frequent Colds/Flu
- ☐ Fever/Chills

Muscle & Skeletal System
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain/Stiffness
- ☐ Shoulder/Elbow/Arm Pain
- ☐ Hand/Wrist/Finger Pain
- ☐ Walking Problems
- ☐ Hip/Leg Pain/Sciatica
- ☐ Foot Pain
- ☐ Jaw Pain or Clicking
- ☐ Difficulty Chewing

Nerve System
- ☐ Numbness - Where?
- ☐ Cold/Tingling Extremities - Where?
- ☐ Weakness/Paralysis - Where?
- ☐ Dizziness
- ☐ Confusion/Depression
- ☐ Seizures/Convulsions
- ☐ Face Pain/Tic Doulareaux
- ☐ Hyperactivity

Gastro-intestinal System
- ☐ Abdominal Pain/Cramps
- ☐ Heartburn/Indigestion
- ☐ Hiatal Hernia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Nausea/Vomiting
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Black/Bloody Stool
- ☐ Liver Problems/Jaundice
- ☐ Gall Bladder Problems
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst

Cardiovascular & Respiratory Systems
- ☐ Breathing Difficulty/Wheezing/Asthma
- ☐ Lung Problems/Congestion/Cough
- ☐ Chest Pain
- ☐ Heart/Artery Disease
- ☐ Circulation Problems
- ☐ Irregular Heartbeat
- ☐ Blood Pressure Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Eyes - Ears - Nose - Throat
- ☐ Vision Problems
- ☐ Crossed Eyes
- ☐ Hearing Difficulty
- ☐ Sore Throat/Laryngitis
- ☐ Chronic Stuffed/Runny Nose
- ☐ Sinus Problems/Infections/Headaches
- ☐ Nose Bleeds
- ☐ Itchy/Watery Eyes
- ☐ Enlarged Glands
- ☐ Loss of Smell or Taste Perception
- ☐ Ear Aches/Noises/Infection

Urinary System
- ☐ Pain or Burning Upon Urination
- ☐ Discolored Urine
- ☐ Excessive Urination Frequency
- ☐ Urinary Hesitancy
- ☐ Kidney Disorders
- ☐ Bladder Disorders
- ☐ Bed-Wetting/Incontinence

For Men Only:
- ☐ Impotence
- ☐ Prostate Disorders

For Women Only:
- ☐ PMS
- ☐ Menstrual Cramps
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain
- ☐ Yeast Infection
- ☐ Breast Pain/Lumps
- ☐ Menopause Symptoms
- ☐ Infertility

Date of your last menstrual period_____

Are you Pregnant?
☐ Yes ☐ No ☐ Not Sure

ACCIDENT/INJURY HISTORY:

Name _____ **Date:** _____

- □ Male □ Female Age _____ Height_____ Weight_____ Date & Time of Accident_____
- **Please describe the accident:** _____

_____

_____

Please check the box next to any of the following conditions that you have had since the accident:

□ Neck Pain/Stiffness □ Headaches/Migraines □ Low Back Pain □ r Pain Between Shoulders

□ Shoulder/Elbow/Arm Pain □ Hand/Wrist/Finger Pain □ Walking Problems □ Hip/Leg Pain/Sciatica

□ Dizziness □ Confusion/Depression □ Vision Problems □ Mid Back Pain

□ Hearing Difficulty/Ear Noises/Ringing □ Difficulty Standing □ Difficulty Sleeping

□ Numbness - Where?_____ □ Cold/Tingling Extremities - Where?_____

□ Weakness/Paralysis - Where?_____ □ Breathing Difficulty/Wheezing/Asthma

- **Were you the** □ Driver □ Front Passenger □ Rear Passenger?
- **If a traffic violation was issued, who received it?** □ Self □ Driver □ Person who hit your vehicle
- **Did the police come to the accident site?** □ Yes □ No
- **Were there any witnesses?** □ Yes □ No
- **Were you wearing a seatbelt?** □ Yes □ No
- **Which way was your head turned at time of impact?** _____
- **Was the vehicle equipped with airbags?** □ Yes □ No If Yes, did they inflate? □ Yes □ No
- **In relation to the base of your skull, where was the headrest?** □ above □ below □ at same level
- **What did your vehicle collide with?** □ another vehicle □ other (explain):_____
- **Did any part of your body strike anything in your vehicle?** If Yes, describe:_____

_____

- **Make & Model of vehicle you were in**_____
- **Street location of accident:**_____
- **Approximately what speed were you traveling?** _____mph □ My vehicle was stopped
- **Approximately what speed was the other vehicle traveling?** _____mph
- **What part of your vehicle was hit?** □ Rear □ Front □ Right Side □ Left Side □ other:_____
- **Did you go to the hospital?** □ Yes □ No Name of the hospital:_____
- **If yes, when did you go?** □ just after the accident □ next day □ 2 days or more after
- **How did you get to the hospital?** □ ambulance □ private transportation

- **Were x-rays taken?** □ Yes □ No If yes, what areas of your body?_____
- **Where drugs prescribed?** □ Yes □ No Type?_____
- **What type of treatment did you get ?**_____
- **Which best describes your discomfort?** □ ache □ sharp/stabbing □ burning □ pins & needles □ numbness
- **Rate how much it bothers you - on a scale of 1 (discomfort) to 10 (extreme pain)**_____
- **What activities/positions/etc. makes it feel worse?**_____
- **What makes it feel better?**_____
- **Does your current condition ever cause you to be:** □ moody □ irritable □ unpleasant □ depressed □ angry
- **What is your occupation?**_____**How does your condition interfere with your work?**

□ decreased productivity □ hard to concentrate □ can't work without pain □ had to stop working/disabled

- **What activities have you been forced to stop or hesitate doing because of your condition?**

□ athletic/exercise activities □ r household work - lifting, etc. □ gardening □ walking □ biking □ dancing

□ running □ other (please list):_____

- **Check any of the following drugs & treatments you have used unsuccessfully to get rid of this problem:**

  □ tylenol □ advil □ aspirin □ aleve □ motrin □ antacids □ sinus medicine □ blood pressure pills

  □ muscle relaxers □ ice □ heat □ massage □ herbal or remedies □ bengay or other ointments

  □ pain medicine injections □ prescription pain medicine (please list):_____

  □ bed rest □ other (please list):_____

- **Check off any tests or evaluations you have had for this condition(s):**

□ x-ray □ MRI □ CAT scan □ bone scan □ blood tests □ other_____

- **Check off any type of doctors you've consulted for this condition(s):**

□ general medical physician □ orthopedist's □ neurologist □ rheumatologist □ cardiologist's

□ dermatologist □ podiatrist □ dentist □ pediatrician □ psychiatrist □ allergist □ OB/GYN □ herbalist

□ gastrointestinal/internal medicine □ urologist □ oncologist □ opthalmologist □ pain clinic

□ lung specialist □ ear, nose & throat □ sports medicine □ physical therapist □ osteopath □ physiatrist

□ **other chiropractor(s):** Who?_____

How long and often did you go?_____ When was your last appointment

Please describe any other pertinent health information you are aware of:

_____

_____

_____

PAST HEALTH HISTORY - *Check any of the following conditions you have ever had:*

□ Pneumonia □ Mumps □ Influenza □ Rheumatic Fever □ Small Pox □ Pleurisy □ Polio □ Chicken Pox
□ Arthritis □ Tuberculosis □ Diabetes □ Epilepsy □ Whooping Cough □ Cancer □ Mental Disorders
□ Measles □ Thyroid □ Eczema □ Psoriasis □ Tonsillitis □ Tested HIV positive

- **Have you ever had any surgery?** □ yes □ no Type:_____
- **Have you ever been hospitalized?** □ yes □ no Why?_____

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: _____ Birth Date: _____ / _____ / _____

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other_____

Height: _____ feet _____ inches

Weight: _____ lbs

Phone #: _____

Zip Code: _____

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other _____

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? _____

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes...

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

Last known blood pressure reading? _____/_____

If unknown was it normal? _____ Are you medicated for blood pressure? _____

ACCIDENT/INJURY INFORMATION:

Name: _____ **Date:** _____

Date of Accident _____ Time of Accident _____

Your automobile insurance carrier: _____

Claim #: _____

Contact Person Name: _____ Telephone #: _____ Extension: _____

The other driver's automobile insurance carrier: _____

Claim #: _____

Contact Person Name: _____ Telephone #: _____ Extension: _____

Did the police come to the accident site: Yes / No

Was a ticket issued: Yes / No Who received the ticket: Yes/ No

Do you have legal representation: Yes / No

Name of attorney: _____ Telephone # of attorney: _____

Please read and sign

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignments of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company. If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductible to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit. If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network, your healthcare provider may bill its full charges to your automobile insurance. You may want to consult your insurance agent or attorney before signing this form,. You are not required to sign this form to receive care. However, if you do not sign this form, you will be required to pay for services at the time the services are provided to you.

I, _____, understand that it is my responsibility to provide Dr. David Block Family Chiropracitc with accurate third party information to assist with payment for any services rendered me. I understand that it is my responsibility to inform Dr. David Block Family Chiropractic immediately should any of the above information change. I also understand that failure to report any known changes, or to receive any settlement without notification to Dr. David Block Family Chiropractic will result in any fees for professional services to be immediately due and payable. I hereby authorize and direct my attorney, my insurance company, the defendant, the defendant's insurance company, and/or the defendant's attorney to pay directly to Dr.David Block Family Chiropractic such sums in full as may be due and owing him for health services rendered to me by reason of this accident.

Patient Signature: _____ Date: _____

Guardian/Spouse/or Guarantor's Name Authorizing Care

_____ Date: _____

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____("Patient") and Dr. David Block Inc.("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 33.3%) until fully paid. Interest rates on unpaid balances is 19.8% and begins from the time an account has become past due. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_____(patient initials)

Patient

Patients Signature_____ Date _____

Health Care Provider

Printed Name_____ Date_____

Block Family Chiropractic
1108 Madison Plaza Chesapeake VA 23320
(757) 436-5428/ (757) 436-5325

AUTHORIZATION FOR TEXT MESSAGING

(SMS COMMUNICATIONS)

Patient Name _____ Date of Birth: _____

I understand that:

- Text messages are inherently unsecure because they are transmitted over a public network onto a personal telephone and as such there are inherent risks in using this type of communication. Information texted to me could be received and read by an unauthorized third party.
- It is my responsibility to keep my mobile number up to date with Block Family Chiropractic.
- I should not send PHI or ePHI to Block Family Chiropractic in a text message because of the unsecure nature of text messages.
- I may be charged for text messages by my wireless carrier.
- This Authorization is voluntary and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this Authorization.
- By signing this form, I am allowing Block Family Chiropractic to send text messages to the following mobile number: _____ for the following:
- Block Family Chiropractic will not send PHI a text message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by test message, phone call, or email address.
- My wireless carrier is: AT&T Sprint T-Mobile Verizon Other:_____

Signature(s

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature_____ Date _____

Print Name _____ Relationship to Patient _____

Definitions:

Protected Health Information (PHI): PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services.