



## PATIENT DEMOGRAPHIC (CSH/MM)

Title: Mr. Mrs. Ms. Miss. Sex:  Male  Female Date: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name: \_\_\_\_\_  
Name that I prefer to be called: \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  Widowed  Separated  
Home #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Preferred Language:  English  Spanish  Other: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

### Reason for your visit today

Are you having any pain?  Yes  No Where: \_\_\_\_\_

Please Circle the description of the complain/pain (Please circle all that apply):

Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Constant Intermittent

Do you have any numbness or tingling in your body?  Yes  No Where?

Grade the intensity/ severity: (0 having no pain – 10 being the worst pain) 0 1 2 3 4 5 6 7 8 9 10

### Primary Insurance / Or Auto Insurance (Please provide cards to be copied)

Company Name: \_\_\_\_\_ Through Employer:  Yes  No

Mailing Address: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Attorney (If Applicable): \_\_\_\_\_ Claim Number: \_\_\_\_\_

(If you have a Secondary or Supplement Insurance – Please provide the card to be copied)

### Emergency Contact Information

Contact Name: \_\_\_\_\_

Contact Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

### HIPPA Acknowledgement

By signing below, I am acknowledging that I have received/ read a copy of the Privacy Practice Policy for this office. As well as the Appointment Policy and Insurance Policy. If I wish for anyone other than myself to have access to my personal information at this office, I shall list their name and relationship below.

Name of Person Designated to have access to my personal/ healthcare information:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Confidential Patient Health & History

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Have you ever had any of the following: (Circle Y or N)**

Heart Disease	Y / N	Hepatitis A, B, or C	Y / N	Mumps	Y / N
Diabetes	Y / N	Lung Disease	Y / N	Chickenpox	Y / N
Prolapsed Mitral Valve	Y / N	Rheumatic Fever	Y / N	Whooping Cough	Y / N
Glaucoma	Y / N	Arthritis	Y / N	Scarlet Fever	Y / N
Tuberculosis	Y / N	HIV/ AIDS	Y / N	Diphtheria	Y / N
Bronchitis	Y / N	Kidney Disease	Y / N	Smallpox	Y / N
Liver Disease	Y / N	Thyroid Disease	Y / N	Venereal Disease	Y / N
Measles	Y / N	Ulcers	Y / N	Anemia	Y / N
Stroke	Y / N	Mental/ Psychiatric Dis.	Y / N	Bladder Infection	Y / N
Heart Attack	Y / N	Heart Murmur	Y / N	Migraine Headaches	Y / N
Pacemaker	Y / N	Colitis	Y / N	Polio	Y / N
Metal Implants	Y / N	Epilepsy	Y / N	Hernia	Y / N
Swollen Ankles	Y / N	Artificial Prosthesis	Y / N	Blood or Plasma Transfu.	Y / N
Sinusitis	Y / N	Hearing Loss	Y / N	Back Trouble	Y / N
Asthma	Y / N	Pregnant	Y / N	High Blood Pressure	Y / N
Hemorrhoids	Y / N	Cancer	Y / N	Low Blood Pressure	Y / N
Hives or Eczema	Y / N	Mono	Y / N	Date of Last Chest X-ray	Y / N

**Previous Hospitalizations/ Surgeries/ Serious Illness (Please Explain):**

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**Patient Social History:**

Use of alcohol:    Never    Rarely    Moderate    Daily  
Use of tobacco:    Never    Rarely    Moderate    Previously/ I Quit (date) \_\_\_\_\_    Current packs/day: \_\_\_\_\_  
Use of Drugs:    Never    Type: \_\_\_\_\_    Frequency: \_\_\_\_\_

**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

**Do you have any medication allergies?**

- No known medication allergies
- Yes. Name: \_\_\_\_\_  
Name: \_\_\_\_\_  
Name: \_\_\_\_\_

**Are you currently taking any medications?**

- Not currently prescribed any medications
- Yes.    Name: \_\_\_\_\_ mg \_\_\_\_\_  
Name: \_\_\_\_\_ mg \_\_\_\_\_  
Name: \_\_\_\_\_ mg \_\_\_\_\_  
Name: \_\_\_\_\_ mg \_\_\_\_\_

**\*Are you on Birth Control Medication?**     Yes     No    If yes, how long? \_\_\_\_\_



## Symptom Survey

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Head:** **Headaches:** Mild Moderate Severe **How Often (circle)?** \_\_\_\_\_ Times per: Day Week Month

**Description of Pain:** Sharp Dull Achy Constant Intermittent **Migraine:** Yes No

**Location:** Back of head Forehead Temples Right Side Left Side Behind Eyes

**Other symptoms:** Dizziness Nausea Memory loss Slurred speech Other: \_\_\_\_\_

**Jaw:** **Pain:** Right Left Both **Clicking/Popping:** Right Left Both

**Neck:** **Description of Pain:** Mild Moderate Severe **Locations:** Right Side Left Side Both

**Are you having any of following:** Stiffness Muscle Spasm Grinding Sounds

**Pain increased by:** Fwd Movement Backward Movement Rotate Head Right

Rotate Head Left Bend Head Left Bend Head Right

**Shoulder:** **Pain Location:** Right Left Both **Pain Level:** Mild Moderate Severe

**Type of Pain:** Sharp Stabbing Dull

**Upper:** **Upper Arm Pain:** Right Left Both **Numbness:** Right Left Both **Pins and Needles:** Right Left Both

**Extremity:** **Forearm Pain:** Right Left Both **Numbness:** Right Left Both

**Pins and Needles:** Right Left Both

**Hand Pain:** Right Left Both **Numbness:** Right Left Both **Pins and Needles:** Right Left Both

**Upper Back Pain:** Right Left Both **Type of pain:** Sharp Stabbing Dull **Spasms:** Right Left Both

**Mid Back:** **Pain Location:** Right Left Both **Numbness:** Right Left Both **Pins and Needles:** Right Left Both

**Type of Pain:** Sharp Stabbing Dull **Muscle Spasms:** Right Left Both

**Low Back:** **Back Pain Level:** Sharp Stabbing Dull **Pain Location:** Left Right Both

**Lower:** **Upper Leg Pain:** Right Left Both **Numbness:** Right Left Both **Pins and Needles:** Right Left Both

**Extremity:** **Low Leg Pain:** Right Left Both **Numbness:** Right Left Both **Pins and Needles:** Right Left Both

**Foot Pain/Ankle:** Right Left Both **Numbness:** Right Left Both **Pins and Needles:** Right Left Both

**\*Other issues not listed:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

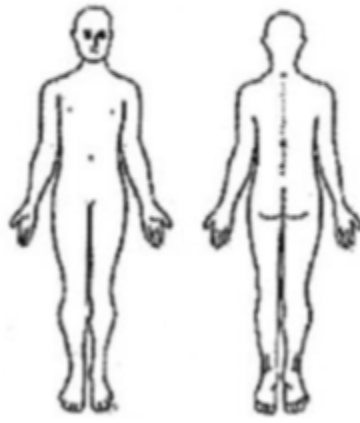
1. Please list any and all other problems you are having as a result of this injury: \_\_\_\_\_  
\_\_\_\_\_

2. Briefly describe how your daily activities have changed due to this injury: \_\_\_\_\_  
\_\_\_\_\_

3. Briefly describe how your issues began and when: \_\_\_\_\_  
\_\_\_\_\_

**Pain Questionnaire**

Using the appropriate symbols, please indicate on the figure the location and sensation of your pain today.

Numbness	(N)	
Tingling	(T)	
Burning	(B)	
Stabbing	(G)	
Aching	(A)	
Stiffness	(S)	
Pins/Needles	(PN)	
Other	(O)	

My pain level today is:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
 Comfortable      Tolerable      Moderate      Painful      Intense

Any additional information about your symptoms please explain here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **Notice of Initiation of Treatment**

Name of Insured Patient: \_\_\_\_\_

Name of PIP Insurer: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Name of Health Ins.: \_\_\_\_\_

Health Member #: \_\_\_\_\_

### **Please fill in below if involved in a Motor vehicle accident!**

Pursuant to Florida statute 627.736(5)(c)1., you are hereby notified that treatment on your insured,

\_\_\_\_\_ was initiated on  
\_\_\_\_/\_\_\_\_/\_\_\_\_ for injuries sustained in an automobile accident on  
\_\_\_\_/\_\_\_\_/\_\_\_\_.

### **All patients must sign Initiation of Treatment!**

\_\_\_\_\_

Patient/Guardian signature

\_\_\_\_\_  
Dr. Joseph Troiani, DC. / Dr. Theresa Troiani, DC

\_\_\_\_\_  
Date



ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

**INSURANCE CARRIER:** \_\_\_\_\_ **DATE OF LOSS:** \_\_\_\_\_  
**AUTO CLAIM NUMBER:** \_\_\_\_\_ **OR HEALTH MEMBER#:** \_\_\_\_\_

For and in consideration of Advanced Spine & Injury Center agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Advanced Spine & Injury Center for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Advanced Spine & Injury Center to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract.

**THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.**

I hereby further give a lien to Advanced Spine & Injury Center against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Advanced Spine & Injury Center as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Advanced Spine & Injury Center and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Advanced Spine & Injury Center including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Advanced Spine & Injury Center and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Advanced Spine & Injury Center will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Advanced Spine & Injury Center at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Advanced Spine & Injury Center at the address on the bill. Advanced Spine & Injury Center medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Advanced Spine & Injury Center. I further instruct my insurance company to make payment for charges submitted by Advanced Spine & Injury Center in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Advanced Spine & Injury Center limited power of attorney to endorse and sign my name on any draft for payment to Advanced Spine & Injury Center or myself if said draft represents payment for charges related to services rendered by Advanced Spine & Injury Center.

I further direct my insurance carrier or responsible other entity to provide information to Advanced Spine & Injury Center which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Advanced Spine & Injury Center. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Patient Signature/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

*If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.*

10205 Wilsky Blvd. Tampa, FL. 33625 (P) 813-265-8555 (F) 813-265-8645

**www.AdvancedSpineChiropractic.com**



## **INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-Rays; on myself (or the patient named below, for whom I am legally responsible for) by the doctor of Advanced Spine & Injury Center and/ or other licensed doctors of Advanced Spine & Injury Center facility, who now of in the future treat me while employed by ,working with, associated with or serving as a back-up for the doctor of Advanced Spine & Injury Center, including those working within Advanced Spine & Injury Center.

I have had an opportunity to discuss with the doctor of Advanced Spine & Injury Center and or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as with the practice of chiropractic, carries some risks of treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 of which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I have read, or had had read to me, the above consent. I have also had an opportunity to ask question about its 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(s) and for any future condition(s) for which I seek treatment for.

To be completed by patient:

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Patient's Guardian



## Appointment Agreement

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours' notice to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor, and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

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Patient/Guardian Signature

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Date

## Insurance Agreement

The first visit charges are payable when services are rendered, unless another arrangement has been made with this facility. The fee paid for treatment X-rays is for analysis only. The film itself is property of this office. Once films are used for treatment purposes, they cannot be released. Copies may be made if necessary.

I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. Furthermore, I understand that Advanced Spine & Injury Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Advanced Spine & Injury Center will be credited to my account upon receipt. However, ***I clearly understand and agree that I am personally responsible for payment.***

I have read the above information and certify all my insurance information to be true and correct to the best of my knowledge and hereby authorize this office to provide me with care in accordance with this states' statutes.

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Patient/Guardian Signature

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Date





## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date



## Patient Request for Records

Today's Date: \_\_\_\_\_

To (Doctor/ Hospital): \_\_\_\_\_

Address of Facility: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize the release of ANY and ALL medical records in your facility to be copied/sent/transferred to:

Dr. Joseph Troiani, DC.  
Dr. Theresa Troiani, DC.  
Advanced Spine & Injury Center  
10205 Wilsky Blvd  
Tampa, FL 33625  
Telephone: 813-265-8555  
Fax: 813-265-8645

Print Patient Name: \_\_\_\_\_

Date of Records: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date