Klein Chiropractic Center

1906 Clint Moore Rd. Ste 4
Boca Raton, Fl 33496
Phone: (561) 988-1998

Dr. Robert I. Klein

PERSONAL HISTORY

Date ____________________ Social Security # ____________________

Name: ____________________ Address: ____________________

City: ____________________ State: ____________________ Zip ____________

Mailing Address: ____________________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Sex: ____________ Height: ____________ Weight: ____________

Birthdate: ____________________ E-mail: ____________________

Name of Your Employer: ____________________ Type of Work:

Check If You Are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name and Telephone # of Person to Contact In Case of Emergency: ____________

Name of Husband or Wife: ____________________ Spouse's Employer's Phone #: ____________________

Husband or Wife's Employer: ____________________

Ages of Your Children: ____________________

Referred To This Office by: ____________________

Who Is Responsible For Your Bill? ☐ Self ☐ Husband or Wife ☐ Employer ☐ Insurance ☐ Other: ____________

PAST HEALTH HISTORY

PLEASE CHECK APPLICABLE ITEMS:

OPERATIONS:

Appendectomy ____________ Rectal ____________ Tonsillectomy ____________

Gall Bladder ____________ Female Organs ____________ Hernia ____________

Others: ____________

ACCIDENTS OR FALLS (Please describe) ____________________

FRACTURES OR DISLOCATIONS: ____________________

HABITS:

Sleep (hours) ________ Coffee ________ Tea ________ Alcohol ________

Tobacco ________ Exercise ________ Hobbies ________

Arc you now taking any drugs'? (Please name) ____________________

Have you ever had a nervous breakdown? ____________________

Have you or any member of your family been treated for a mental disorder? ____________________

INSURANCE PLAN

You are responsible for meeting the payment requirements of your policy regarding deductibles and co-payments, and also payment for services not covered by your policy. With the above exceptions, in most cases we will accept assignment and payment of benefits of the patient's Insurance benefits, health plans, and third party claims as payment in full for services rendered. Check type of Insurance coverage:

☐ Workman's Compensation ☐ Automobile Insurance Policy
☐ Government Health Plan ☐ Group Policy
☐ Personal Policy ☐ Other

It is hereby agreed by the undersigned that should the balance owed for service become delinquent, that is, thirty (30) days past due from the date of the original invoice, I shall remain liable for any and all collection costs, attorneys fees and/or Interest as a result of collection of the delinquent account.

PATIENT'S SIGNATURE ____________________

CIRCLE ANY OR THE FOLLOWING DISEASES YOU HAVE HAD;

Appendicitis
Scarlet Fever
Diphtheria
Typhoid Fever
Pneumonia
Rheumatic fever
Polio

Malaria
Tuberculosis
Whooping Cough
Anemia
Measles
Mumps
Small Pox

Chicken Pox
Diabetes
Cancer
Heart Disease
Goiter
Influenza
Pleurisy

Alcoholism
Venereal Infection
Arthritis
Epilepsy
Mental Disorder
Lumbago
Eczema

Please Underline All of the Following Symptoms You Have Had Previously. Please Circle All of the Following Symptoms You Have Now

GENERAL SYMPTOMS

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness or pain in arms, hands, or legs Allergy
Wheezing
Neuralgia

E.E.N.T.

Failing vision
Near sightedness
Far sightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
Hay Fever

SKIN

Skin Eruptions
Itching
Bruises easily
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing

CARDIOVASCULAR

Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Previous heart stroke Hardening of arteries Swelling of ankles Poor circulation Paralytic stroke

MUSCLE & JOINT SYMP.

Stiff neck
Backache
Swollen joints
Tremors
Painful tail bone
Foot trouble
Pain between shoulders
Hernia
Spinal curvature
Faulty posture

GENITOURINARY SYMPTOMS

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

GASTROINTESTINAL * SYMPTOMS

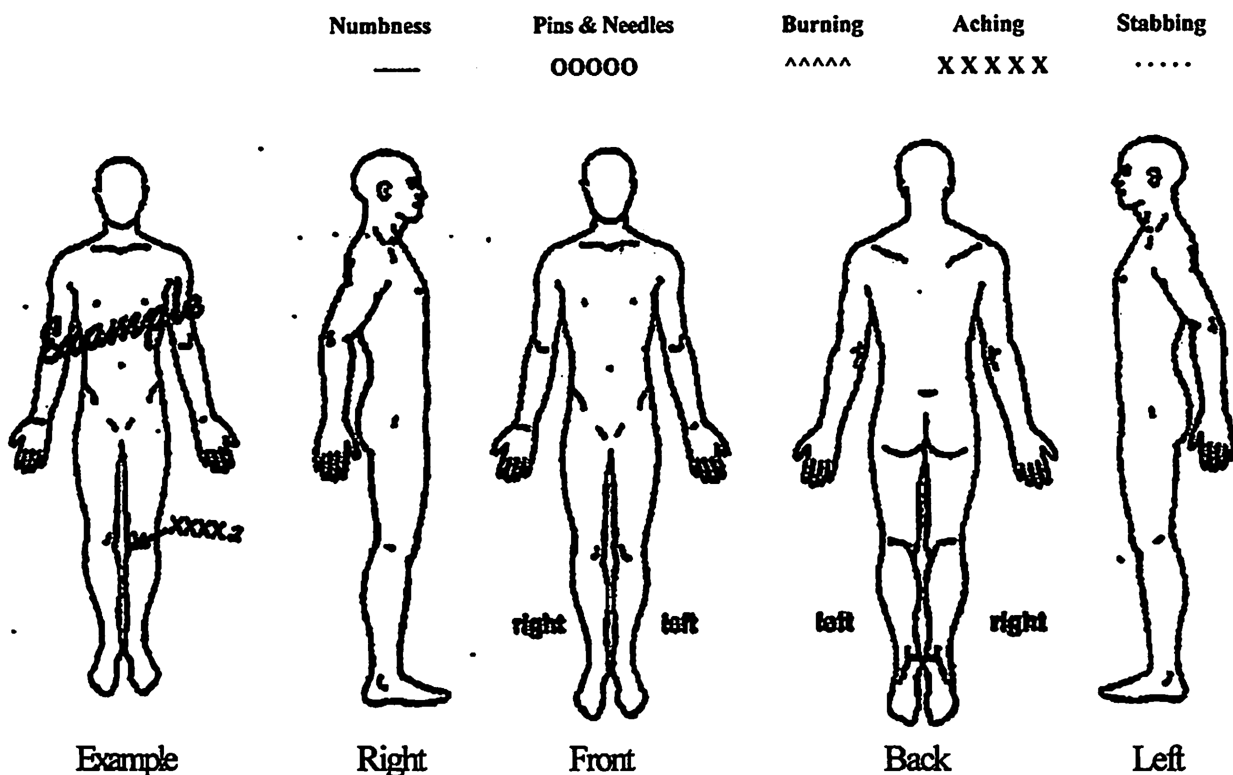
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (Piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

FOR WOMEN ONLY

Painful menstrual periods
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Lumps in breast
Menopausal symptoms
Are you pregnant? ☐ Yes ☐ No

PAIN CHART

PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS ILLUSTRATED BELOW.



Example   Right   Front   Back   Left

USING THE SCALE BELOW, PLEASE INDICATE THE DEGREE OF PAIN USING A SCALE OF 1 (MILD DISCOMFORT) TO 10 (EXTREME PAIN)

1 2 3 4 5 6 7 8 9 10 11 12

- **We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient**
- **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment I also authorize the provider *to* release any information required to process insurance claims.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.**

Patient Consent for Use and Disclosure of Protected Health Information

Klein Chiropractic Center

I hereby give my consent to Klein Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Klein Chiropractic Center's Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Klein Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Klein Chiropractic Center 1906 Clint Moore Rd. Ste 4, Boca Raton, Fl 33496

With this consent, Klein Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Klein Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Klein Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Klein Chiropractic Center's use and disclosure of PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Klein Chiropractic Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian__________________________ Date ____________________

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_____________________________________, have read a copy of Klein Chiropractic Center's Notice of Privacy Practices.

Signature of Patient or Legal Guardian__________________________ Date__________________________