PATIENT HISTORY QUESTIONNAIRE
(HISTORIAL DEL PACIENTE)

Last Name : _____ **First Name:** _____
(Apellido) (Nombre)

Address/ (Direccion): _____

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

Home # _____ **Cell phone #** _____

Work # _____ **Email :** _____

Emergency Contact Name: _____ **Phone #** _____

Relationship: _____

Sex: (Sexo) M / F **Birth Date:** (Fecha de Nacimiento) _____/_____/_____ **SSN** _____

Health Insurance (Plan Medico): _____ **Phone#** _____

Address: _____

Subscriber ID # _____ **Group #** _____

BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THIS OFFICE FOR PROFESSIONAL SERVICE RENDERED, AND I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE TO THE DOCTOR, I HEREBY AUTHORIZE THE ATTENDING DOCTOR TO RELEASE ANY INFORMATION CONCERNING MY EXAMINATION OR TREATMENT THAT MAY BE NECESSARY OF EITHER MEDICAL CARE, LEGAL DOCUMENTATION OR PROCESSING APPLICATION FOR FINANCIAL BENEFITS.

BENEFICIOS

YO AUTORIZO PAGO DIRECTO A ESTA OFICINA POR SERVICIOS PROFECIONALS RECIVIDOS, SOY PERSONALMENTE RESPONSIBLE POR SERVICIOS MEDICOS NO PAGADOS, AUTORIZO A EL DOCTOR A REVELAR CUALQUIE INFORMATION QUE CONSIERNA MI CONSULTA O TRATAMIENTO RESIVIDOS YA SEA A MI SEGURO, ABOGADO, OTROS MEDICOS.

Patient Signature: _____ **Guardian:** _____ **Date:** _____
(Firma del Paciente) (Tutor) (Dia)

CHECK THE SYMPTOMS YOU NOTICED
(MARQUE LOS SINTOMAS QUE HA NOTADO)

- ☐ Headaches [Front / Mid / Back]/ Dolor de cabeza [Alfrente / Medio / Atras]
- ☐ Dizziness / Mariado
- ☐ Head Seems too heavy / Cabeza pesada
- ☐ Chest Pain / Dolor de Pecho
- ☐ Neck Pain / Dolor De Cuello
- ☐ Neck Stiffness / Cuello Inmovil
- ☐ Neck pain radiating to / Dolor de cuello corimiento al
  - ☐ Right Shoulder/ Ombro derecho
  - ☐ Left Shoulder/ Ombro Izquierdo
- ☐ Pins and needles in Arms/ Hands / Siente Punsadas en los Brazos/Manos
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Hip pain
- ☐ Difficulty Bending/ Dificulta Agachandose
- ☐ Difficulty Lifting/ Dificultad Alsando cosas
- ☐ Difficulty Prolong Sitting/ Dificultad Mantenerce Sentado/a
- ☐ Difficulty Prolong Standing/ Dificultad Mantenerce Parado
- ☐ Upset Stomach / Dolor de estomago
- ☐ Fainting / Desmallos
- ☐ Nervousness / Nerviosismo
- ☐ Fatigue / Fatiga
- ☐ Tension / Tencion
- ☐ Irritability / Inrritabilidad
- ☐ Loss of balance / Perdida de balance
- ☐ Depression / deprecion
- ☐ Buzzing in Ears / Ruido en el Oido
- ☐ Light bother eyes / Le molesta la Luz
- ☐ Sleeping Problem / Problemas para dormir
- ☐ Other /Otros: _____

Comments/Comentarios:

Have you been diagnosed with / or treated for (Alguna Vez a Sido Diagnosticado De)

☐ Diabetes / Diabetes	☐ Epilepsy / Epilepcia	☐ Kidney Disease / Problemas del Rinon
☐ Hypertension / Alta Presion	☐ Cancer / Cancer	☐ Heart Disease /Problemas del carazon
☐ Scoliosis	☐ Osteoporosis	☐ Arthritis
☐ Pacemaker/ Marca Paso	☐ Metalic Implant/ Implante metalico	☐ other _____

Are you employed: (Esta Trabajando) ☐ Yes/Si ☐ No/No
If Yes, Where do you work? (Si, En Donde) _____

What type of work you do? (Que Tipo de Trabajo) _____

ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Address: _____

Date of Loss: _____

Insurance Company: _____

Name of Policyholder: _____

Policy Number: _____

Claim Number: _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to **Dr. Terry McSweeney**, hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

2. I, assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.

3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.

5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.

6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medicals bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

7. In the event that the insurance carrier and/or the vendor designated by the insurance carrier does not accept my assignment, or my assignment is challenged for being invalid, I execute this limited/special power of attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the carrier in my name and/or allow the medical provider to amend the law suit and/or arbitration to include my name.

Signed: _____

Patient's Name: _____

Dated: _____

Witness: _____

Mount Prospect HEALTH CENTER
NEWARK, NEW JERSEY

600 Mount Prospect Avenue
Newark NJ, 07104
(973) 485-2332
Fax: (973) 485-6878

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I legally responsible:_____) by the chiropractic physician and/or other anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician at Mount Prospect Health Center and or/other licensed Physician of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. McSweeney and or/ with other office or clinic personnel the nature and purposes of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cove the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by the patient's Representative, if necessary, (e.g. If the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

Physician Signature _____ Date_____/_____/_____