Patient Demographics Form

Patient Information

First Name:_____ M.I:_____ Last Name:_____

Date of Birth:_____/_____/_____ SSN:_____

Gender (circle one): M F

Marital Status (circle one) Never Married Married Annulled Divorced Domestic Partner
Interlocutory Legally Separated Polygamous Widowed Unknown

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ - _____ - _____ Cell:_____ - _____ - _____

Email Address:_____

Smoking Status (check one): ____ Unknown ____ Everyday ____ Some ____ Former Smoker
____ Never Smoke ____ Smoker Status Unknown ____ Not Given by Patient.

Preferred Language (check one): ____English ____ Spanish ____ Other (specify):_____

Ethnicity (check one): ____ Hispanic or Latino ____ Not Hispanic or Latino ____ Not given by patient
____ Unknown by patient

Race (check one): ____ American Indian/Alaska Native ____ Asian ____ Black/African American ____ White
____ Native Hawaiian/Other Pacific Islander ____ Other ____ Not Given by Patient

Preferred Contact Method (check one): ____ Phone ____ Email

Occupation:_____

Employer's Name:_____

Address:_____

City:_____

State:_____ Zip Code: _____

Phone:_____

Is Patient a Minor? (check one) ____ No ____ Yes (if yes, please fill out information below)

First Name:_____ M.I:_____ Last Name:_____

Date of Birth:_____/_____/_____ SSN:_____

Gender (circle one): M F

Marital Status (circle one) Never Married Married Annulled Divorced Domestic Partner

Interlocutory Legally Separated Polygamous Widowed Unknown

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ - _____ - _____ Cell:_____ - _____ - _____

Email Address:_____

Next of Kin

First Name:_____ M.I:_____ Last Name:_____

Relationship to Patient:_____

Phone Number:_____

If you are currently under the care of your family physician or specialist such as a neurologist or surgeon, please complete the information below. This allows us to communicate directly with these doctors and use a team approach to treat your condition most effectively.

We routinely send these doctors an initial report as well as interim reports so they can stay familiar with your case and any progress or changes that result from our care.

Name of Family Physician/Primary Care Provider:_____

Office Location:_____ Phone Number:_____

Name of any specialist consulted/treated for your condition:

(ex: neurologist/orthopedic surgeon):_____

Office Location:_____ Phone Number:_____

Performance Spine & Sport Rehabilitation
STEPHEN M. SWARINGEN, DC
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
Tel: 561-400-1528 Fax: 561-412-1277

Assignment of Benefits

Patient Name: _____ Date: _____
Claim/Group #: _____ SSN/ID#: _____

I authorize and assign to you, Stephen M. Swaringen, DC D/B/A Performance Spine & Sport Rehabilitation, the right to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay us any sums. I further authorize the endorsement of my name to any drafts containing my name to which you are legally entitled.

I hereby instruct and direct my insurance company to pay electronically or by check made out and mailed directly to:

STEPHEN M. SWARINGEN, DC
D/B/A Performance Spine & Sport Rehabilitation
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
EIN# 81-3413019

OR

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

C/O 1408 N Killian Rd. Ste 106, Lake Park, FL 33403

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Signature of policy holder: _____ Date: _____

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PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so, I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At this present time, (*Please at the corresponding line*)

_____ I am sure that **I am not pregnant.**

_____ It is possible that **I could be pregnant.**

_____ **I am pregnant.**

_____ _____
Signature—Patient Date

_____ _____
Signature—Witness Date

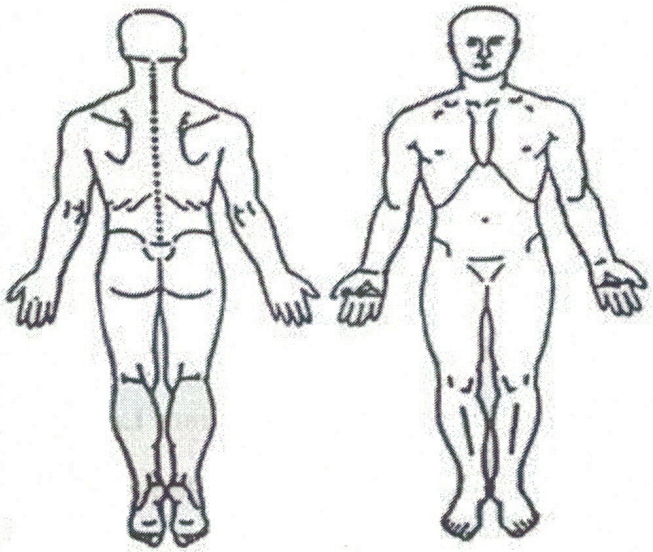
PERFORMANCE SPINE & SPORT REHABILITATION
Dr. Stephen M. Swaringen, DC

Reasons for Visit: _____
Date of injury or symptoms? _____ How did it start? _____
What Makes it better? _____ Worsened by: _____
The pain is: constant / frequent/ occasional Are you Pregnant? ☐ Yes ☐ No, _____weeks
Is there anything you can not do due to your condition? _____
_____
Past Medical History (medical conditions, illness, significant injuries, surgeries, previous treatments): _____
_____
Personal History (type of work, social activities, physical activities): _____
_____
Family Medical History (arthritis, cancer, auto-immune diseases, diabetes, etc): _____
Medications:
Name: _____ Name: _____
Name: _____ Name: _____
Medication Allergies:
Name: _____ Name: _____
Name: _____ Name: _____
Primary Care Physician/ Surgeon: _____ Location: _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

(#) Numbness
(0) Pins & Needles / Tingling
(X) Burning
(S) Sharp Pain
(/) Stabbing Pain
(+) Dull Ache

Please mark neck to each symptom area the intensity using numbers from 1-10 (1 is minimal to 10 is unbearable).



Name: _____ Date: _____

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Consent to Evaluation and Treatment

I hereby request and consent to the performance of chiropractic adjustments, various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Stephen M. Swaringen, DC and/or other licensed Doctors of Chiropractic or Physical Therapists or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Stephen M. Swaringen, DC. I understand and I am informed that, in the practice of chiropractic and physical therapy that there are some risks to examination and treatment including, but not limited to, bruising, soreness, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no improvement of symptoms or pain. 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 judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future conditions(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy

The office of Stephen M. Swaringen, DC is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside of our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Stephen M. Swaringen, DC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent to Treatment of Minor/Child

I hereby authorize Stephen M. Swaringen, DC and his staff to administer chiropractic and/or physical therapy treatments as deemed necessary to my _____ (indicate relationship of child), _____.
(Name of child)

Patient or Guardian Signature: _____ Date: _____

MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Performance Spine & Sport Rehabilitation
Stephen M. Swaringen, DC
1408 N Killian Rd. Ste 106, Lake Park, FL 33403
Tel: 561-400-1528 Fax:

☐ To provide copies of records to **Self**.
☐ To **Disclose** information to: ☐ To **Receive** Information from:

Name of Doctor/Provider: _____
Address: _____
City/State/Zip Code: _____
Phone: _____ Fax: _____ Email: _____

Information to be disclosed include copies of:
☐ Entire Record ☐ Progress Notes ☐ Daily Notes ☐ Lab Results/Test
☐ MRI / Reports ☐ X-Rays / Reports
☐ Other, specify: _____

* X-ray films are originals (considered medical records) and must be returned to this office within 30 days. Digital x-rays on CD are copies and need not be returned.

Purpose for disclosure: ☐ Treatment/Payment OR ☐ Other, specify: _____

This authorization with be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original. **I understand that I may be charged a fee for record copies.**

_____ **Date:** _____
Signature of Patient

_____ **Date:** _____
Signature of Legal Representative/Relationship
(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

RockBlade, Massage, Manual Therapy Questionnaire and Informed Consent

Please answer the following questions. Read the statements concerning *RockBlade, Massage, and/or Manual Therapy*, and sign below. If you have any questions, please speak with your clinician.

1. Do you bruise easily? ☐ Yes ☐ No
2. Do you bleed for a long period of time after you cut yourself? ☐ Yes ☐ No
3. Are you taking blood thinners or anticoagulants? ☐ Yes ☐ No
4. Do you take aspirin on a regular basis? ☐ Yes ☐ No
5. Do you take cortisone on a regular basis? ☐ Yes ☐ No
6. Have you ever had inflamed veins or blood clots? ☐ Yes ☐ No
7. Do you have surgical implants in your body? ☐ Yes ☐ No
8. Do you have diabetes or kidney disease? ☐ Yes ☐ No
9. Do you currently have any infections? ☐ Yes ☐ No
10. Do you have uncontrolled high blood pressure? ☐ Yes ☐ No

RockBlade, Massage, and/or Manual Therapy are forms of treatment used to break up or mobilize myofascial adhesions, increase lymphatic drainage and circulation, and reduce discomfort or pain thus allowing for the return of normal function in the area being treated.

RockBlade, Massage, and/or Manual Therapy may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

RockBlade, Massage, and/or Manual Therapy techniques are designed to minimize discomfort; however, the above reactions are normal, and in some instances unavoidable.

RockBlade, Massage, and/or Manual Therapy techniques have several basic components. Your clinician will determine the protocol for you.

1. Warm up of the treatment area.
2. RockBlade, Massage, and/or Manual Therapy assisted soft tissue manipulation.
3. Joint Mobilization.
4. Therapeutic Modalities.
5. Static Stretching.
6. Dynamic Mobility.
7. Isometric Exercise.
8. Resistance Training.
9. Impact Training.

All components of RockBlade, Massage, and/or Manual Therapy have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print your name: _____ Date: _____

Your signature: _____