Name: Date:

Patient Information

New Patient **Returning Patient**

Last Name	First Name	Middle Initial

Date of Birth MM/DD/YYYY ____/____/________	Sex: Male Female	Social Security #

Address	City	State	Zip Code

Primary Phone Number: Home Work Cell	Secondary Phone Number: Home Work Cell	Preferred Contact Method: Phone call Text Email
Marital Status Single Widowed Divorced Married Separated Partner	**Email** To be used for provider communication, follow up, patient portal, and practice related material. We DO NOT share email information with other parties. You may choose to remove at any time.	**Employment Status** Full time Part time Not employed Student Homemaker Retired
Preferred Language English Spanish Other ________________________	**Employer**	**Job Title**
Race American Indian or Alaska Native / Native Hawaiian or Other Pacific Islander / Other Race Asian / Black or African American Unreported Hispanic / White		**Preferred Pharmacy:**

Insurance Information

Primary Insurance Company	
Name of Policy Holder Same as above	Policy Holder's Date of Birth Same as above ____/____/________
Policy Holder's Relationship to Patient Self Mother Father Other ____________________	Policy Holder's Social Security # Same as above
Subscriber Number	Group Number
Secondary Insurance Company N/A	Name of Policy Holder Same as above
Secondary Subscriber Number	Secondary Group Number

In Case of Emergency

I hereby give permission to disclose and discuss any information related to my medical condition(s) with the following listed individuals:

Name	Relationship	Phone Number	Yes or No

Reason For Today's Visit

Chief Complaint (please describe symptoms)		
Medical Treatment (list symptoms above) Work Related Injury – Worker's Compensation Car Accident or Auto Related Injury Home Injury	Physical - School Work DOT Pre-op Medical Clearance Unknown Cause Other ____________________	Onset/Injury Date

Name: Date:

Please report previous treatment received for condition

Emergency Room	Prescribed Medication	Surgery	Ice	Other: ______________________
Physical Therapy	Over-the-counter Medication	Rest	Heat	Other: ______________________
Massage	Chiropractic Adjustment	Stretching	Bracing	Other: ______________________

Current Medications Prescribed by Another Provider or anything you are taking over the counter

Medication	Dosage	Condition

Medical History (check all that apply)

ADD/ADHD	Chronic Fatigue Syndrome	Hearing Impairment	Pacemaker
AIDS/HIV	Constipation	Heart Disease	Parkinson's Disease
Allergies	COPD	Heart Murmur	Pinched Nerve
Alzheimer's/Dementia	Depression	Hepatitis	Scoliosis
Anemia	Diabetes: Insulin / Non-insulin	Herniated Disk	Seizure Disorder
Appendicitis	Ear Infections	Herpes/Lesions/Shingles	Sinusitis
Arthritis	Eating Disorder	High Blood Pressure	Sleep Apnea
Asthma	Eczema	High Cholesterol	STD
Autoimmune Condition	Eye Problems	Hypoglycemic	Stroke/ TIA
Back Pain	Fainting /Syncope	Influenza/ Pneumonia	Thyroid Problems
Bleeding Disorder	Fibromyalgia	Joint Pain	Tonsillitis
Bronchitis	Fractures	Kidney Disease/ Stones	Tumors/Growths
Cancer: ____________________	Gallbladder Disorder	Measles/ Mumps/ Rubella	Ulcers
Cataracts	Glaucoma	Miscarriage	Vaginal Infections
Chest Pain	Gout	Mononucleosis	Vertigo
Chicken Pox	Headaches	Osteoporosis	Other:

Allergies

Medication Allergies:	Reaction:
Supplement Allergies:	Reaction:
Food Allergies:	Reaction:
Other:	Reaction:

Name: Date:

Surgical History (check all that apply)

Angioplasty	Debridement	Lumpectomy
Arthroscopy	Dilation and Curettage	Mastectomy
Appendectomy	Ear Tubes	Pacemaker/Defibrillator
Biopsy (site):	Eye Surgery (specify):	Skin Lesion Removal
Bunionectomy	Gallbladder Removal	Spinal Surgery (type):
Cardiac Surgery (type):	Gastric Bypass	Thyroid Surgery
Carpal Tunnel	Hernia	Tonsillectomy
Cesarean Section	Hysterectomy	Tubal Ligation
Colostomy	Joint Replacement	Vasectomy
Cosmetic (type):	Kidney Surgery	Other:
Any hospitalizations besides surgeries?		

Family History Please Circle: Mother: Alive/Deceased Father: Alive/Deceased

Check all that apply. Please indicate family member associated with condition: **M-Mother, F- Father, S-Sister, B- Brother, MG- Maternal Grandmother, MF- Maternal Grandfather, MA- Maternal Aunt, MU- Maternal Uncle, PG- Paternal Grandmother, PF- Paternal Grandfather, PA- Paternal Aunt, PU- Paternal Uncle, C- Child**

Condition	Family Member	Condition	Family Member	Condition	Family Member
ADD/ADHD		Diabetes		Obesity	
Alcoholism/Substance Abuse		Eczema/Psoriasis		Parkinson's Disease	
Alzheimer's/Dementia		Heart Disease		Psychiatric Disorder	
Arthritis		Hemodialysis		Seizure Disorder	
Asthma		Hepatitis		Stomach or GI problems	
Auto Immune Disease (ex: Lupus)		High Blood Pressure		Stroke/TIA	
Cancer (type):		High Cholesterol		Thyroid Problems	
COPD		Kidney Disease		Other:	

Social History

Exercise Habits: Daily Minimal 3-4 x per week None 1-2 x per week None Due to Injury/Illness	Tobacco Use: Never Smoked Smokeless Tobacco Current Smoker Vaporizer Former Smoker Amt/Day ____________ # of years _________	Alcohol Use: ________ Drinks Per Week Caffeine Use: ________ Cups Per Day
Drug Use: No history of recreational drug use Former use of recreational drugs Current use of recreational drugs	Work Habits: N/A Average # of hours per week ______________ Mostly- Sitting Standing Walking Labor- Sedentary Light Moderate Heavy Environment- Difficult Stressful Relaxed Enjoyable	

Name: Date:

Review of Systems (check all that apply)

CONSTITUTIONAL Weight Loss Fatigue Fever	**ENDOCRINE** Loss of Hair Heat/Cold Intolerance	**HEMATOLOGY/LYMPH** Bruising Gums Bleed Easily	**CARDIOVASCULAR** Murmur Chest Pain Palpitations Dizziness Fainting Spells Shortness of Breath Difficulty Lying Flat Swelling Ankles **ALLERGIC/IMMUNOLOGIC** Hives Eczema Hay Fever
EYES Glasses/Contacts Eye Pain Double Vision Cataracts	**GASTROINTESTINAL** Heartburn/Reflux Nausea/Vomiting Constipation Change in bowel movements	**MUSKULOSKELETAL** Joint Pain Swelling Stiffness Muscle Pain Back Pain	
EAR, NOSE, THROAT Difficulty Hearing Ringing in the Ears Vertigo Sinus Trouble Nasal Stiffness Frequent Sore Throat	**GENITOURINARY** Burning/Frequency Night Time Blood in Urine Erectile Dysfunction Abnormal Discharge Bladder Leakage	**NEUROLOGICAL** Loss of Strength Numbness Headaches Tremors Memory Loss	
RESPIRATORY Cough Easy Wheezing Chills	**PSYCHIATRIC** Anxiety/Depression Mood Swings Difficulty Sleeping	**SKIN** Rash/Sores Lesions Itching/Burning	

Name: Date:

IMPORTANT INSURANCE INFORMATION:

To patients with Medical Insurance Coverage,

All of our doctors and providers here at Back In Action Medical Center/Best Life Primary Care, have accepted to be a health care provider for certain insurance companies. The insurance you provide us with is a policy you have chosen either as an individual policy or through your employer. Please understand that we **DO NOT** determine the **Coverages, stipulations, frequencies or clauses** on your insurance plan. It is **your responsibility** to understand the coverages, stipulations, frequencies & clauses in your plan.

Our office staff requests a **BASIC** "breakdown of Benefits" by either Automated service, Fax, or Online.

(It will be electronically generated from your insurance company or clearinghouse)

We then give you an **ESTIMATED COPAYMENT/DEDUCTIBLE** price based on the information received from your insurance. Please keep in mind that in some cases, if you have a visit(s) in other facilities the maximum or deductibles may change your Out-Of-Pocket expenses. Most of the time we are not aware of other claims that may be processed when we figure out your estimated copay and or deductible. Therefore, you may have to pay more than what was originally calculated as your estimated payment.

Once services are rendered, our billing team will submit the claim to your insurance company with any imaging and or other necessary attachments. Once your insurance company processes the claim, we both will get a breakdown of benefits that will explain in detail what was paid and how it was determined by your insurance carrier.

If there is a balance on your account for the difference that we have collected, you will then receive a bill from our office or be asked to pay it on your next office visit. If there was an overpayment on your account, it will be applied as a credit and will be used for your next date of service.

OUTSIDE LABORATORY AND RADIOLOGISTS

Please understand that **BACK IN ACTION MEDICAL CENTER** may send lab specimens to an outside laboratory or send X-Rays taken by **Back In Action** to an outside Radiologist for over reading. I give permission for those outside laboratories and Radiologists to bill my insurance for their services. I understand that I may incur additional charges as a result of those outside laboratory tests or radiologist. I understand that **BACK IN ACTION** is not responsible for payment to those laboratories and/or radiologist.

(Please keep I mind that our contracted rates may change year to year with different insurance companies, therefore may result on us making certain debit or credit adjustments to your account.)

- **Please understand it is your responsibility to update our office with any changes. Including, Health insurance, Address change, & Contact information**.

Thank you,

Print:____

Signature:___________________________________ Date:___________________

Name: Date:

Ownership Notice to Patients

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has an ownership interest, Florida passed a law (the "Patient Self-Referral Act of1992," FL Statute Section 455.654).

Under this law, I must disclose my ownership in this facility and tell you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have the right to obtain healthcare items or services at a location or from a provider or supplier of your choice, including the facility in which I am owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

Dr. Robert McLaughlin has an ownership in: Back In Action Medical Center, LLC, Proactive Health and Wellness, dba Back In Action Chiropractic, and Access 365 Urgent Care, PMB Health Solutions LLC/dba Back In Action Chiropractic, and M&R Wellness Center, LLC/ dba Back In Action Chiropractic

Dr. Michael Purificati has an ownership in PMB Health Solutions LLC/dba Back In Action Chiropractic and M&R Wellness Center LLC/dba Back In Action Chiropractic

Alternative Medical facilities in which we do not have ownership:

1. Jensen Beach Urgent Care
2. Med Stat Urgent Care
3. Martin County Department of Health
4. Dr. G's Urgent Care
5. Helix Urgent Care

Alternative Chiropractic facilities in which we do not have ownership:

1. Complete Care Chiropractic
2. Life Chiropractic
3. Vital Wellness Center
4. Keystone Chiropractic
5. Hoffman Chiropractic

Patient Name ______________________________

Signature ______________________________

Date _____________________________

If not patient, name of legal guardian:____________________________Relationship___________

Name: Date:

Medical Information Release Form

(HIPAA Release Form)

This ***Release of Information*** will remain in effect until terminated by me in writing.

Name: ___________________________________ Date of Birth: _____________________

Release of Information

[] I authorize the release of information including the diagnosis, records;

Examination rendered to me and claims information. This information may be released to:

[] Spouse_______________________

[] Child _________________________

[] Other ________________________

[] Information is not to be released to anyone

Messages

Please call [] my home [] my work [] my cell number: __________________________.

If unable to reach me:

[] you may leave a detailed message

[]please leave a message asking me to return your call

[] _______________________________________.

The best time to reach me is (day) ____________ between (time) ____________.

Signed: ______________________ Date:__/__/_____

Witness: ______________________Date:__/__/_____

Name: Date:

Informed Consent For Disclosure Of Medical Health Information

Patient Name:______________________________ Former Name:_________________________________

Date Of Birth:_______________________________

I Authorize the Following Health Care Provider:

Disclosing Party's Name (health care Provider)____

Street Address:____

City, State, Zip:____

Phone:_______________________________________ Fax:____

To Disclose to the following Party:

Disclosing Party's Name (health care Provider)____

Street Address:____

City, State, Zip:____

Phone:_______________________________________ Fax:____

__These Records Are Needed For AN Appointment on____

Requesting The Following Information:

__Last (2)Office Notes __Lab Reports __Imaging Reports __EKG

__Other:____

Disclosure is Being Made For the Following Purpose:

__Continuing Care __Insurance/Claims __Legal __Personal Information __Other:_____________

Patient/Legal Representative Signature:________________________________ **Date:**_______________

Name: Date:

When an appointment is scheduled for you with Michael Carpino or Misty Gaddis at Back in Action/Best Life Primary Care, it is your responsibility to confirm your appointment 24hrs prior to the appointment time. The front desk team will call and or email you to confirm your appointment. In the event you do not answer a voice mail will be left. If you as the patient do not make conformation of your scheduled appointment within 24hrs your appointment will be canceled and rescheduled for a later date. If the appointment is confirmed and you do not show up, you will be billed a $50.00 no show fee. We understand that circumstances will arise that will result in you having to cancel please give us a courtesy call 24hrs prior to your scheduled time to prevent the no show fee being charged.

We value you as one of our patients and hope you understand why this is a necessary office policy.

Please sign and date below stating your acknowledgement of this policy.

Print Name:____

Signature:____

Date:____________________