PERSONAL DATA SHEET

Please Print:

Date: ______________________ Social Security #: ______________________ File # ________________

Name: ________________________________ Spouse's Name: ________________________________
First MI Last First MI Last

Address: ____ ____________ __________ __________
City State Zip

Sex: M / F Female only: Pregnant Y / N DOB: ____________ Age: ________________

Telephone #: Home ____________________ Mobile/Cell __________________________

Circle: Married Single Divorced Widowed Separated Domestic Partner

Employer: ____ Phone #: ______________

Address: ____ Status: Full Time Part Time Retired

Referred to Office By: (Circle) Physician Phone Book Ad Friend Newspaper
Business Card Sign Patient If referred, by whom? ________________

Who is responsible for your bill? Self Spouse Employer Insurance Other

How will payment be made? Cash Check Insurance Visa / Mastercard

Insurance type: Workman's Compensation Auto/PIP Personal Policy Medicare Medicaid

Primary Insurance Company ____

Primary Insured Name ____

Relationship to Primary Insured ____

If applicable: Secondary Insurance Company ____

Secondary Insured Name ____

Previous Chiropractic Care **Yes** **No** By Whom: ________________________________

Results: ____

Family Physician ________________________________ PH#: ______________________

Emergency Contact: ______________________________ PH#: ______________________

Relationship: ______________________

Fees are payable at the time examinations, and treatments are received, unless other arrangements are made in advance.

* *

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and from policy to policy. Therefore, although we will fill out the insurance forms, the patient is responsible for payment of the bill. We do accept insurance assignments but all insurance arrangements must be approved. Any unpaid debt to Dr. Mark T. Machuga, P.A. that ultimately has to result in legal action or collection, the debtor will be responsible for interest penalties of 1-1/2% per month and collection fees incurred by Dr. Mark T. Machuga, P.A. as a result of a said collection.

I authorize the release of any medical or other information necessary to process this claim and authorize direct payment of insurance benefits to Dr. Mark T. Machuga, P.A.

________________________________ ______________________
Patient or Legal Guardian Signature **Date**

Patient Medical History

Name: ______________________________ Date: ____________ File # ____________

Sex: M / F Female only: pregnant Y / N Date of Accident / Injury: ______________________

The following list describes common symptoms or conditions. Please mark any and all conditions you are experiencing or have experienced in the past.

Please check all applicable:	Present	Past
Headaches		
Dizziness		
Blurred Vision / Loss of Concentration		
Depression		
Nervousness		
Difficulty Sleeping		
Buzzing / Ringing in the Ears		
Loss of Energy / Fatigued		
Fainting		
Other:		

Do you have any problems with the following:

Please check all applicable:	Present	Past
Head / Sinus		
Neck Pain / Stiffness		
Arm Pain / Numbness (which side)		
Shoulder Problems (which side)		
Upper Back / Mid Back		
Low Back		
Chest Pain		
Lung		
Heart / Palpitations		
Stomach / Indigestion		
Bladder / Kidney		
Liver		
Colon / Constipation		
Hip / Leg Pain (which side)		
Numbness (where?)		
Poor Circulation		
Other Problems:		

Additional Information

Please list below if you have had any previous injuries, surgeries, etc, or if you have seen any other doctors for this condition or any other condition.

Please check all applicable:	Present	Past
Hospitalization / Surgeries / Implants / Fractures		
Accidents / Falls		
Auto Accidents		
Worker's Compensation		
Family History of Back Problems:		
(i.e. mother, father, sister, brother, etc.)		

To the Patient

Please read this entire document prior to signing that you have read it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you *are consenting* to the following procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Range of motion testing
- Orthopedic testing
- Other ____________________
- Basic neurological testing
- Muscle strength testing
- Postural analysis
- Electric Muscle Stimulation
- Ultrasound
- Hot/cold therapy
- Ear / Eye Exam
- Radiographic studies
- Past history evaluation

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contribution to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination or X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are all generally described as rare.

Terms of Service Agreement

Services and products offered in a chiropractic practice are treatments, and there is no guarantee as to their success. Payments are the patient's responsibility, regardless of insurance compensation or the effectiveness of care. The practice cannot provide refunds for payment of services provided or some products purchased. The patient is responsible for any co-pays or other out-of-pocket expenses.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers
- Hospitalization or outpatient procedures, such as epidural spinal blocks
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are more risks and benefits of such options and you may wish to discuss these with your primary medical physician, or the physician rendering the procedure.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. Your underlying condition will likely perpetuate in time, causing further deterioration to your body.

Patient Name: ____________________ **Date:** ____________

Patient/Legal Guardian Signature: ____________________

Dr. Mark T. Machuga, D.C. P.A.

1554 BOREN DRIVE, SUITE 300
OCOEE, FL 34761

P (407) 877-9771
F (407) 877-8505

MEDICAL RECORDS RELEASE AND AUTHORIZATION

Patient's Name: ______________________ DOB: ______________

SSN#: ______________________

I REQUEST AND AUTHORIZE ______________________ P ______________

F ______________

✓ To release healthcare information of the patient named above to: **Dr. Mark T. Machuga, D.C.**

This request and authorization applies to:

☐ Complete Medical File ☐ A specific portion/section of the record as follows: ______________

☐ Medical record for the period ______________ through ______________

☐ Medical Reports / Daily Notes ☐ X-Ray Film(s) ☐ X-ray Report(s) ☐ MRI Film(s) ☐ MRI Report(s)

☐ Diagnostic studies: ______________________

Purpose of requested disclosure: ☐ Initiation of Treatment ☐ At patient's request ☐ Continuing care

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the privacy officer. I am aware that my revocation is not effective to the extent that the person I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that **Dr. Mark T. Machuga** may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the release of information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release.

If I authorize **Dr. Mark T. Machuga** to fax information, I realize there are inherent risks in faxing Protected Health Information; I understand a fee will be charged to cover the cost of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I may request a copy of this form after I sign it.

Patient or Representative's Signature: ______________________

Date signed: ______________

Witness: ______________________

THIS AUTHORIZATION EXPIRES TWO YEARS FROM THE DATE SIGNED UNLESS REVOKED SOONER IN WRITING

CONSENT FOR TREATMENT

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had the opportunity to discuss it with Dr. Mark T. Machuga to have my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

______________________________ ______________________________

Print Name **Date**

____

Patient or Legal Guardian Signature

****

Please check **<u>one</u>** of the following:

☐ 1. I hereby give permission to the following individual(s) to have <u>access</u> to my medical information:

1)______________________________ 2)______________________________

3)______________________________ 4)______________________________

<u>Or</u>

☐ 2. I do **not** want my medical information disclosed.

****

NOTICE OF PRIVACY PRACTICES

I, ______________________________ have received a copy of this office's "Notice of Privacy Practices".

______________________________ ______________________________

Patient or Legal Guardian Signature **Date**

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

****

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our "Notice of Privacy Practices", but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement.
( ) An emergency situation prevented us from obtaining acknowledgement.
( ) Other (Please Specify) ______________________________

Chart # ________

DR. MARK T. MACHUGA, D.C., P.A.

1554 Boren Drive, #300, Ocoee, FL 34761

P (407) 877-9771 F (407) 877-8505

We are in the process of updating our records to comply with federal standards; please answer the following questions:

Patient Name: ______________________________ Date: ____________

DOB: _____/_____/_______ Age: __________ Height: _________

(Please circle one)

Hand Dominance: Right Left Ambidextrous

Preferred Language: English Spanish Other: ____________________

Smoking Status:

Current every day smoker Current some day smoker Former smoker

Never smoker Unknown if ever smoked Heavy tobacco user Light tobacco user

Medications Dosage / Milligrams (mg)

☐ Not currently prescribed any medications

1. ______________________ ______________________
2. ______________________ ______________________
3. ______________________ ______________________
4. ______________________ ______________________

Please list additional medications on the back of this form, or provide a copy of your current medications.

Allergies (Medication allergies, food allergies, etc)

☐ No Known Drug Allergies (NKDA)

______________________ ______________________

______________________ ______________________