HORNBERGER CHIROPRACTIC CENTER 1180 Beneva Road So. Sarasota, FL 34232 (941) 366-2440

Patient Information

Today's Date________________

Name____SS#________________

Address____ Male______ Female________

City______________________State________________Zip____________Marital Status M S W D

Date of Birth________________ Age______ Home #______________ Work #______________

Number of Children ______ Mobile/Cell #______________ (may we call you on any of these numbers? _YES _NO)

Occupation________________________________Employer________________________________

Work Address____Work Phone________________

Spouse's Name____Occupation________________

Employer____Work Phone________________

Nearest Relative not living with You____

Address____Phone________________

Insurance Information: Insured Name:____________________________ ID #____________________

Carrier Name:____________________________ Contact #____________________

*Please provide the office with your ID cards for verification purposes.

Referred By____

Have you ever suffered from? Yes or No

Dizziness	____	Asthma	____	Tuberculosis	____	Sinus Trouble	____
Arthritis	____	Anemia	____	Headaches	____	Cancer	____
Backaches	____	Neuritis	____	Heart Trouble	____	Digestive Order	____
Diabetes	____	Nervousness	____				

Purpose of This Appointment____

Other Doctors Seen for This Condition____

Has a Physician Treated You for Health Condition in the Past Year? Yes_____ No____

Describe____

Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Joseph P. Hornberger, M.S., D.C., P.A., will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Joseph P. Hornberger,M.S., D.C. P.A, will be credited to my account upon receiving. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. Furthermore, I hereby voluntarily consent to examination, diagnostic treatment and/or Chiropractic care by Hornberger Chiropractic Center, its physicians and employees as explained to me by the attending physician and whomever he may designate as his assistant. I am aware that the science of Chiropractic/Medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees have been made to me as a result of any treatment or examination in the office.

Patient's Signature____ Date______________

Guardian or Spouse's Signature______________________________ Date______________

Information Taken By______________________________________ Date______________

Full Legal Name:____________________ DOB:__/___/____

PATIENT HISTORY

Complete each section as accurately as possible as it will become a permanent part of your record. If a question is not applicable, please leave blank.

PAST MEDICAL HISTORY: Place an (X) if it applies and describe, i.e. year, joints injured, months treated, residuals, etc.

[ ] None [ ] Operation____________ [ ] Auto Accident ____________
[ ] Work Accident ____________ [ ] Illness ______________ [ ] Other ________________
Describe:____
____

FAMILY HISTORY: Place an (X) if any family member (father, mother, brother, sister) has suffered from any of the following:

[ ] Tuberculosis [ ] Epilepsy [ ] Arthritis [ ] Gout
[ ] Hypertension [ ] Diabetes [ ] Mental Illness [ ] Stroke
[ ] Migraines [ ] Cancer [ ] Kidney Disease [ ] Heart Attack
[ ] Spinal Disorders [ ] Allergies [ ] Other
List Other:____

PERSONAL HISTORY: Place an (X) if it applies and describe if necessary.

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widow/Widower
[ ] # children [ ] Employed Spouse **DRINKING:** [ ] Alcohol per day [ ] Caffeine per day
EXERCISE: [ ] no. of times weekly [ ] daily **SMOKING:** [ ] packs per day

Describe below: [ ] Congenital [ ] Medications [ ] Disease [ ] Other
____
____

SYSTEM REVIEW: Place an (X) next to the symptoms you now have.

Genito-Urinary System
[ ] Bladder Trouble
[ ] Excessive Urination
[ ] Scanty Urination
[ ] Discolored Urine
[ ] Painful Urination
[ ] Other

CARDIO-VASCULAR
[ ] Chest Pain
[ ] Coughing Phlegm
[ ] Heart Problems
[ ] Pain over heart
[ ] Coughing blood
[ ] Lung problems
[ ] Difficult Breathing
[ ] Rapid Heartbeat
[ ] Varicose Veins
[ ] Persistent Cough
[ ] Blood Pressure
[ ] Other

Gastro-Intestinal System
[ ] Poor Appetite
[ ] Vomiting Food
[ ] Bloody Stool
[ ] Excessive hunger
[ ] Vomiting Blood
[ ] Hemorrhoids
[ ] Difficult Chewing
[ ] Abdominal Pain
[ ] Liver Trouble
[ ] Difficult Swallowing
[ ] Diarrhea
[ ] Gall Bladder
[ ] Excessive thirst
[ ] Constipation
[ ] Weight Trouble
[ ] Nausea
[ ] Black Stool
[ ] Other

Nervous System
[ ] Numbness
[ ] Fainting
[ ] Forgetfulness
[ ] Loss of feeling
[ ] Headaches
[ ] Confusion
[ ] Paralysis
[ ] Muscle Jerking
[ ] Depression
[ ] Dizziness
[ ] Convulsions
[ ] Other

Eyes,Ears,Nose/Throat
[ ] Eye Strain
[ ] Eye Inflammation
[ ] Vision Problems
[ ] Ear pain
[ ] Ear Noises
[ ] Ear Discharge
[ ] Hearing loss
[ ] Nose Pain
[ ] Nose Bleeding
[ ] Nose Discharge
[ ] Breathing
[ ] Sore gums
[ ] Dental problems
[ ] Sore mouth
[ ] Sore throat
[ ] Hoarseness
[ ] Speech difficulty
[ ] Other

OTHER:____

PATIENT SIGNATURE:________________________________ DATE:____/____/_____

*HONRBERGER CHIROPRACTIC CENTER
JOSEPH P. HORNBERGER, M.S., D.C., P.A.
1180 S. BENEVA RD
SARASOTA, FL 34232

List the Doctor(s) You Have Seen Previously for This Injury in Order of Occurrence:

Doctor #1______________________________

Address______________________________

Treatment Received______________________________How Long Treated______________

What Were the Results______________________________

Were You Referred to Another Doctor: Yes_____ No____

Who Were You Referred to______________________________

Doctor #2______________________________

Address______________________________

Treatment Received______________________________How Long Treated______________

What Were the Results______________________________

Were You Referred to Another Doctor: Yes_____ No____

Who Were You Referred to______________________________

Doctor #3______________________________

Address______________________________

Treatment Received______________________________How Long Treated______________

What Were the Results______________________________

Were You Referred to Another Doctor: Yes_____ No____

Who Were You Referred to______________________________

List Any and All Prior Injuries or Accidents (Auto, Work Related, Etc.)

1. Type of Injury______________________________

   Date It Occurred____________Resulting Injuries______________________________

2. Type of Injury______________________________

   Date It Occurred____________Resulting Injuries______________________________

3. Type of Injury______________________________

   Date It Occurred____________Resulting Injuries______________________________

* C:\WINDOWS\Profiles\April\My Documents\forms\doctor seen list.doc

HORNBERGER CHIROPRACTIC CENTERS

Joseph P. Hornberger, M.S.,D.C., P.A.

1180 Beneva Rd. South
Sarasota, FL 34232

(941) 3662440
Fax: (941) 955-3336

Dear Patient:

I would like to take this opportunity to first welcome you to our office.

This letter will help you understand our front desk procedure with all patients – this procedure is called the ***"one stop system"***. This means that you will only have to stop at the front desk only one time during your visit at our office. Traditionally a patient usually checks in at the front desk and then after seeing the doctor checks out to reschedule, pay for their visit, etc.

Our process is to be more efficient at the time of check in where you would sign in, schedule your future appointment/s and pay for your visit at that time. This means you will not have to check back at the front desk when you finish your adjustment and/or therapy.

What this means is that you will be paying for services, re-scheduling, and be self-directed to an adjusting room prior to seeing the doctor. The doctor will then direct you to the therapy room, massage therapist, and/or x-ray if needed based on your needs prior to you leaving the office after your adjustment. *We do believe that this process will save you more time.*

I truly appreciate your cooperation and participation in helping us maintain a stress relief environment.

I would be more than happy to discuss any questions regarding this policy – please do not hesitate to speak with me personally.

Thank you,

Dr. Joseph P. Hornberger, M.S., D.C., P.A.

PATIENT SIGNATURE:________________________________ DATE:______________

WORKERS COMP Patient Information form:

First Name______________ M.I._____ Last Name___________________________

ID#___________

Sex_______ D.O.B.________________ Social Security #______-____-_______

Insured

First Name_________________ M.I._____ Last Name ______________________

Sex_______ D.O.B.____________ Social Security Number______-____-________

Address____

City___________________ State_____ Zip__________ Phone (___)____-_____

Insurance

Insurance Carrier ____

Address_____________________________City___________________State_____
____

Zip_________ Policy #__________________ Claim #________________________

Phone(___)____-_________

Employer

Current Employer ____

Address_____________________________City___________________State_____

Zip_______ Group #________________________________

Phone(____)_____-___________

Date of Injury ______/______/____________

Time of Injury ______:_________am ____pm

Date of 1st Tx ______/______/____________

Is this injury a;

____ Auto Accident ____ Work Comp Injury

Previous Treatment and Conditions: ______________________________

____

____

____

____

____

____

____

History of Onset

(injury)____

____

____

____

____

____

____

____

Workers Compensation Injuries

Injuries involving Lifting:

From where were you lifting the object?____

____

How many pounds was the object you were lifting? ____________________

What position were you in while lifting the object? ______________________

What type of pain did you feel immediately after the injury? _______________

____

Injuries involving Falling:

Where at work did you fall?______________________________________

____

What part of your body did you land on? ____________________

____

What other areas were injured as a result of your fall? ____________________

____

Other work related injuries:

Other type of accident (if not caused by lifting or a fall)?____________________

____

____

____

____

Job Analysis:

What regular activities to you perform at your job? ____________________

____

____

How much do you regularly lift at your job? ____________________

____

____

Are you required to regularly bend over while lifting at your job? ____________

____

Are your hands subject to repetitive movements?__________ Such as?

____

____

____

How many hours are you required to regularly perform each of the following activities at your job?

Sitting ____________

Standing ____________

Walking____________

Lifting ____________

Check below if applicable:

___ Did you report this injury in writing at work?

___ Have you seen another health care provider since the accident? If so who did you see, what was the recommendation and/or treatment, how long did you treat for, and what was your response to the treatment

____

____

____

____

____

Did you have any previous past injuries? ...if so what were they, how did it happen, and do you still have problems resulting from those injuries?

____

Who treated you for your past injuries?

____

____

Do and did you have any past health problems? ______________________

____

____

____

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Dear Patient:

Based on the Florida Statute 460.413, please be advised that your medical forms and x-ray films are a permanent record of our office for a maximum of 4 years.

If you will need to request the films that were processed in our office there will be a minimum charge of $6.00 per copy. The x-ray technician will be more than happy to advise you in advance of the total cost.

The office policy: Payment must be made prior to duplicating the films and the waiting period for processing would be no longer than 24 – 36 hours.

____________________________ ______________

PATIENT/GUARDIAN SIGNATURE DATE SIGNED

- -

Permission to leave recorded scheduling messages at your designated phone number.

Compliance to the doctor's recommendations is of paramount importance in realizing maximum benefits from your care in our office. With your consideration and permission we will phone to remind you of missed or changed appointment schedules. Messages would be a reminder to phone Dr. Hornberger at our office concerning your appointment. Permission to follow this important procedure is granted by you with your signature.

__________________________________ ____/____/______

PATIENT SIGNATURE ***DATE***

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize Joseph P. Hornberger, M.S.,D.C.,P.A. (HORNBERGER CHIROPRACTIC CENTER) to release a copy of my patient records or x-rays containing protected health information to

____. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

____ ____________________
Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

____________________________________ Date Signed

Specific description of information to be disclosed:

____
____
____
____
____
____
____
____

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