Family Chiropractors of Montclair
39 Watchung Plaza – Montclair NJ
07042 (973)783-5666

New Patient Form

Today's Date: _____

Personal Information

Last Name:_____ First Name: _____

Date of Birth:_____/_____/_____ Sex: Male / Female

Address:_____City:_____State:_____Zip: _____

Primary Phone: (_____)_____-_____Secondary Phone: (_____)_____-_____

Email: _____ Age: _____ Height:_____'_____"

Weight: _____ Blood Pressure:_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Smoking Status: ☐ Smoke Everyday ☐Smoke Some Days ☐Former Smoker ☐ Never Smoked

Have you ever been to a Chiropractor before? ☐ Yes ☐ No

Whom may we thank for your referral? _____

Health Insurance Information

Patient ID #: _____

Insurance Carrier: _____ Primary Card Holder Sex: ☐ Male / ☐ Female

Name of Primary Card Holder: _____

Relation to Patient:_____Primary Card Holder D.O.B:_____/_____/_____

# of Members on Plan: _____

Do you have a secondary insurance? ☐ Yes ☐ No Secondary Insurance Company _____

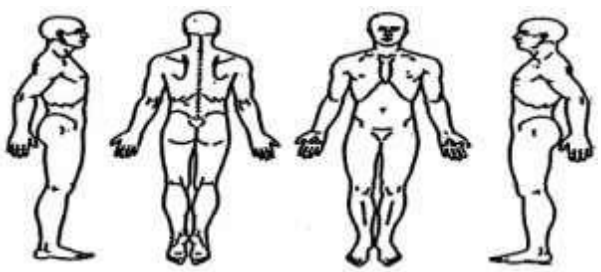
Name of Policy Holder:_____Policy ID #:_____

For confidential correspondence, please create a secret question and answer
ie. What was your first pet's name? Fido:

Question:_____ Answer: _____

Please tell us the reason for your visit: Wellness or Main Complaint?

1. Indicate on the drawings below where you have pain/ symptoms



2. Please check off the location(s) of your problem, and circle "L" for Left, "R" for Right:

☐ Head	☐ Shoulder (L / R)	☐ Hand (L / R)	☐ Leg (L / R)
☐ Jaw	☐ Arm (L / R)	☐ Mid Back	☐ Knee (L / R)
☐ Neck	☐ Elbow (L / R)	☐ Low Back	☐ Ankle (L / R)
☐ Upper Back	☐ Wrist (L / R)	☐ Hip (L / R)	☐ Foot (L / R)

3. How would you describe the type of pain?

☐ Sharp	☐ Burning	☐ Tingly	☐ Electric w/ motion
☐ Dull	☐ Shooting	☐ Sharp w/ motion	☐ Other: _____
☐ Diffuse	☐ Stiff	☐ Shooting w/ motion	
☐ Achy	☐ Numb	☐ Stabbing w/ motion	

4. How often do you experience these symptoms?

☐ Constantly (76 – 100% of the time) ☐ Frequently (51 – 75% of the time)
☐ Occasionally (26 – 50% of the time) ☐ Intermittently (1 – 25% of the time)

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 1 to 10, (10 being the worst), how would you rate your problem? (Please circle one)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. How long have you had this problem? _____ Day(s) / Month(s) / Year(s)

8. How do you think your problem began? ***

_____

9. What aggravates your problem?

☐ Always There	☐ Standing	☐ Sitting	☐ Climbing Stairs
☐ Bending	☐ Lifting	☐ Carrying	☐ Picking Up Child
☐ Reaching	☐ Pulling	☐ Pushing	☐ Deep Breaths
☐ Coughing	☐ Sneezing	☐ Sleeping	☐ Turning Over in Bed
☐ Bathing	☐ Dressing	☐ Driving	☐ Household Chores
☐ Gardening	☐ Shoveling	☐ Stress	☐ Weather Change
☐ Traveling	☐ Work	☐Computer	☐ Playing a Sport: _____
☐ Exercising:_____		☐Physical Work: _____	

10. Who else have you seen for this problem?

☐ Chiropractor	☐ Neurologist	☐ Primary Care Physician
☐ ER Physician	☐ Orthopedist	☐ Massage Therapist
☐ Physical Therapist	☐ No One	☐ Other _____

11. What is your occupation?

☐ Laborer ☐ Teacher ☐ Trader ☐ Tradesperson
☐ Truck Driver ☐ Student ☐ Homemaker ☐ Professional / Executive
☐ Retired ☐ Unemployed ☐ Disabled ☐ Other: _____

12. What do you do at work / throughout your day (check all that apply)?

Sit → ☐ Most of the day ☐ Half of the day ☐ Some of the day
Stand → ☐ Most of the day ☐ Half of the day ☐ Some of the day
Computer → ☐ Most of the day ☐ Half of the day ☐ Some of the day
On the phone → ☐ Most of the day ☐ Half of the day ☐ Some of the day
Drive → ☐ Most of the day ☐ Half of the day ☐ Some of the day
☐ Manual Labor ☐ Read a lot ☐ Travels Frequently

13. How much does your problem interfered with your work or daily routine?

☐ Not at all ☐ A Little Bit ☐ Moderately
☐ Quite a Bit ☐ Extremely

14. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good
☐ Fair ☐ Poor

15. What kind of regular exercise do you perform?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

16. What type of recreational activity do you do?

☐ Aerobics ☐ Play Basketball ☐ Play Baseball
☐ Bicycle ☐ Play Football ☐ Play Golf
☐ Hike ☐ Play Ice Hockey ☐ Inline Skate
☐ Jog ☐ Martial Arts ☐ Rock Climb
☐ Ski ☐ Play Soccer ☐ Play Softball
☐ Swim ☐ Play Tennis ☐ Triathlons
☐ Play Volleyball ☐ Walk ☐ Lift Weights
☐ Work Out ☐ Yoga ☐ Other: _____

17. Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

18. Have you had significant trauma or surgery in the past ? ☐ Yes ☐ No

If yes, please explain: _____

19. **Family History** – Please check all that apply to the following (Select "M" for Mother and "F" for Father):

☐ Rheumatoid Arthritis M / F ☐ Diabetes M / F ☐ Lupus M / F
☐ Heart Disease M / F ☐ Cancer M / F ☐ ALS M / F

20. **Your History** – Please indicate below what conditions you have had both in the past and present:

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Asthma	☐	☐	Muscular Incoordination
☐	☐	Neck Pain	☐	☐	Chronic Sinusitis	☐	☐	Visual Disturbances
☐	☐	Upper Back Pain	☐	☐	High Blood Pressure	☐	☐	Dizziness
☐	☐	Mid Back Pain	☐	☐	Heart Attack	☐	☐	Diabetes
☐	☐	Low Back Pain	☐	☐	Chest Pains	☐	☐	Excessive Thirst
☐	☐	Shoulder Pain	☐	☐	Stroke	☐	☐	Frequent Urination
☐	☐	Elbow/ Upper Arm Pain	☐	☐	Angina	☐	☐	Smoking/ Tobacco Use
☐	☐	Wrist Pain	☐	☐	Kidney Stones	☐	☐	Drug/ Alcohol Dependence
☐	☐	Hand Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Hip Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Upper Leg Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
☐	☐	Knee Pain	☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Lower Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/ Eczema/ Rash
☐	☐	Ankle/ Foot Pain	☐	☐	Abnormal Weight Gain/ Loss	☐	☐	Other: _____
☐	☐	Jaw Pain	☐	☐	Loss of Appetite			
☐	☐	Joint Pain/ Stiffness	☐	☐	Abdominal Pain			**For Females Only:**
☐	☐	Arthritis	☐	☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Rheumatoid Arthritis	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Cancer	☐	☐	Liver/ Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Tumor	☐	☐	General Fatigue			

21. **Medications** – Please list all prescriptions you are currently taking below:
Check here if you are not taking any medications: ☐

Medication: ie: Lipitor	**Strength and Directions:** ie: 10mg, 2 times daily	**Prescribing Physician:**

22. Please List all medications you are allergic to:
Check here if you do not have any allergies: ☐

Name of Medication: Ie: Penicillin	**Reaction:** Ie: Rash and Headache

23. Have you had an Influenza vaccination this year? ☐ Yes ☐ No

24. Is there anything else pertinent to your visit today you would like us to know?

PATIENT'S ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT FAMILY CHIROPRACTORS OF MONTCLAIR IS PERMITTED BY LAW, TO USE MY PERSONAL HEALTH INFORMATION, TO FACILITATE PAYMENT OF ANY FEES AND EXPENSES. FAMILY CHIROPRACTORS OF MONTCLAIR HAS AGREED TO ASSIST ME IN BILLING, MY HEALTH INSURANCE, AUTO INSURANCE AND ANY AND ALL OTHER APPLICABLE COLLATERAL SOURCES, AND ALTHOUGH THE PRACTICE WILL AWAIT THEIR DIRECT PAYMENT, I AGREE I AM FULLY AND PERSONALLY RESPONSIBLE, FOR ALL FEES I INCUR IN CONNECTION WITH SERVICE RENDERED FOR THE PURPOSE OF TODAY'S ENCOUNTER, AS WELL AS ANY FUTURE SERVICES, FOR ANY CONDITIONS, KNOWN OR AS OF YET UNKNOWN.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATE'S STATUTES.

Patient Signature_____ **Date:**_____

STATEMENT OF NON-ACCIDENT

I,_____, am currently receiving chiropractic care at this facility. Please know that this care is **not related** to any auto accident, worker's compensation injury, or any other type of injury in which there is a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

_____ _____

Print Name Signature

HIPPA FORM

We are required by State and Federal Law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the rights to alter or amend the terms of this privacy notice. IF changes are made to our privacy notice we will notify you, in writing, as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

Dr. Luis Mizraji. Privacy Officer
If you would like further information about our privacy policies and practices, please contact:

Dr. Luis Mizraji. Privacy Officer
You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.
This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

_____ _____ _____

Name (please print) Signature Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

_____ _____ _____

Personal Representative (please print) Personal Representative Signature Date

NECK INDEX

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating.
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating.
- ☐ I cannot concentrate at all.

SECTION 7 - Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Patient Signature:_____ **Date:**_____

LOWER BACK INDEX

This questionnaire helps us to understand how much your low back has affected your ability to preform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing.
- ☐ The pain comes and goes and is severe
- ☐ The pain is severe and does not vary much.

Section 2- Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes some pain
- ☐ Washing and dressing increase pain, but I manage not to change my way of doing it
- ☐ Because of pain, I am unable to do some washing or dressing without help
- ☐ Because of pain, I am unable to do any washing or dressing without help

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor
- ☐ Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights at the most

Section 4 - Walking

- ☐ I have no pain on walking
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain
- ☐ I cannot walk more than ½ mile without increasing pain
- ☐ I cannot walk more than ¼ mile without increasing pain
- ☐ I cannot walk at all without increasing pain

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like without pain
- ☐ I can sit only in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than ½ houe
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ I avoid sitting because it increases pain immediately

Section 6 – Standing

- ☐ I can stand as long as I want without pain
- ☐ I have some pain standing, but it does not increase with time
- ☐ I cannot stand longer than 1 hour without increasing pain
- ☐ I cannot stand longer than ½ hour without increasing pain
- ☐ I cannot stand longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases pain immediately

Section 7 – Sleeping

- ☐ I get no pain in bed
- ☐ I get pain in bed but it does not prevent me from sleeping well
- ☐ Because of pain, my normal night's sleep is reduced by less than 25%
- ☐ Because of pain, my normal night's sleep is reduced by less than 50%
- ☐ Because of pain, my normal night's sleep is reduced by less than 75%
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life

- ☐ My social life is normal and gives me no pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing…
- ☐ Pain had restricted my social life and I do not go out much
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of my pain

Section 9 – Traveling

- ☐ I get no pain while traveling
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
- ☐ I get extra pain while traveling, which compels me to seek alternative forms of travel
- ☐ Pain prevents all forms of travel except when I'm laying down
- ☐ Pain restricts all forms of travel

Section 10 – Changing degrees of pain

- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definetly getting better
- ☐ My pain seems to be getting better, but slowly improving
- ☐ My pain is neither getting better nor worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Patient Signature:_____ **Date:**_____

FAMILY CHIROPRACTORS OF MONTCLAIR

MISSED APPOINTMENT AND CANCELLATION POLICY

Family Chiropractors of Montclair are committed to providing exceptional care.

Unfortunately, when one patient cancels without giving enough notice they prevent another patient from being seen. If you miss or cancel an appointment without 12 hour notice (excluding emergencies involving medical, urgent care, or bereavement) you will be charged a $25.00 fee.

Please call us at (973)783-5666 12 hours prior to your scheduled appointment to notify us of any changes or cancellations.

To help insure you don't miss your appointment please ask the front desk about our text message alerts or for an appointment reminder card.

Thank you in advance for your cooperation!

Patient Signature

_____

Date

Family Chiropractors
39 Watchung Plaza
Montclair, NJ 07042
(973) 783-5666

Health Insurance Financial Policy

Since most health insurance plans have a deductible, you must pay 100% of your charges until your deductible is satisfied. Once you have met your deductible, we will accept authorization for direct payment of benefits to this office. You must provide us a copy of your health insurance card.

Upon receipt of this information, we will contact your company to verify the eligibility of chiropractic benefits. All information provided to us by your insurance company included any policy limitations or exclusions will be discussed with you. Since most health insurance plans do not reimburse health care expenses 100%, you may be responsible for your co-payment/co-insurance. CO-PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Patients selecting this option understand this office submits bills and awaits direct payment from insurance companies as a courtesy, and that in no way relieves patients of their financial responsibility to this office. If your insurance company denies or delays reimbursement to this office for any reason, the allowable expenses are your responsibility. MONITORING ANY POLICY LIMITATIONS IS CONSIDERED THE RESPONSIBILITY OF THE PATIENT.

I authorize all insurance companies, third party payers and attorney's to make direct payment of my benefits to Family Chiropractors of Montclair for all monies due to my account for the services I have received. If my policy prohibits assignment, I direct my insurance company to mail all checks made payable to me, directly to Family Chiropractors of Montclair at 39 Watchung Plaza, Montclair, NJ 07042.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
INITIAL EXAM NEW PATIENT	NON ALLOWABLE	$65.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.