SOUTHERN CHIROPRACTIC LIFE CENTER

DR. DAVID MIGDAL
10345 SOUTHERN BLVD.
ROYAL PALM BEACH, FL 33411
(561) 790-6388

Confidential Patient Health Record

Date_____

Name _____Middle Initial: ___Last Name:_____

Address: _____City:_____Zip Code:_____

Date of Birth: ____/____/_____ Sex: Male / Female Marital Status: Single /Married /Divorced /Widow(er)

Occupation: _____Employer_____Work #_____

Cell/Home Phone #_____ SS# _____-_____-_____

Email:_____ Referred By: _____

Insured's Data

Insured's Full Name _____Middle Initial___ Last Name:_____

Insurance Company: _____ID#: _____

Policy Holder's Name:_____ Relationship To Insured:_____

Emergency contact

Contact Name: _____Relationship_____ Phone # _____

List Present Complaints:

1. _____ For How Long _____
2. _____ For How Long _____
3. _____ For How Long _____
4. _____ For How Long _____
5. _____ For How Long _____

Cause of Injury/Illness _____

List Doctors Consulted For This:

Name _____

Name _____

Name _____

What Surgery Have You Had:

1. _____ When _____
2. _____ When _____
3. _____ When _____

List Serious Accidents/Falls:

1. _____ When _____
2. _____ When _____
3. _____ When _____

List Fractures:

1. _____ When _____
2. _____ When _____
3. _____ When _____

List Medications / Diet Supplements

1. _____ Frequency _____
2. _____ Frequency _____
3. _____ Frequency _____

Signature of Patient / Guardian _____ **Date** _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES, INCLUDING VARIOUS MODES OF PHYSICAL THERAPY AND DIAGNOSTICS X-RAYS, ON ME (OR ON THE PATIENT NAMED BELOW, FOR WHOW I AM LEGALLY RESPONSIBLE) BY THE DOCTOROF CHIROPRACTIC NAMED BELOW AND/OR OTHER LICENSED DOCTORS OF CHIROPRACTIC WHO NOE OR IN THE FUTURE TREAT ME WHILE EMPLOYED BY, WORKING OR ASSOCIATED WITH OR SERVING AS BACK-UP FOR THE DOCTOR OF CHIROPRACTIC NAMED BELOW, INCLUDING THOSE WORKING AT THE CLINIC OR OFFICE LISTED BELOW OR ANY OTHER OFFICE OR CLINIC.

I HAVE HAD THE OPPORTUNITY TO DISCUSS WITH THE DOCTOR OF CHIROPRACTIC NAMED BELOW AND/OR WITH OTHER OFFICE OR CLINIC PERSONNEL THE NATURE AND PURPOSE OF CHIROPRACTIC ADJUSTMENT AND OTHER PROCEDURES.

I UNDERSTAND AND AM INFORMED THAT, AS IN THE PRACTICE OF MEDICINE, IN THE PRACTICE OF CHIROPRACTIC THERE ARE SOME RISKS TO TREATMENT, INCLUDINT BUT NOT LIMITED TO, FRACTURES, DISC INJURIES, STROKES, DISLOCATIONS, AND WISH TO RELY ON THE DOCTOR TO EXERCISE JUDGMENT DURING THE COURSE OF THE PROCEDURE WHICH THE DOCTOR FEELS AT THE TIME, BASED UPON THE FACTS THEN KNOWN, IS IN MY BEST INTERESTS.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW I AGREE TO THE ABOVE NAMED PROCEDURES. I INTEND THIS CONSENT FORM TO COVER THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

TO BE COMPLETED BY PATIENT:

PRINT PATIENTS NAME_____

SIGNATURE OF PATIENT_____

DATE: _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE,
E.G. IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

PRINT NAME OF PATIENT_____

PRINT NAME OF REPRESENTATIVE_____

SIGNATURE OF REPRESENTATIVE_____

RELATIONSHIP TO PATIENT_____

SOUTHERN CHIROPRACTIC LIFE CENTER
DR, DAVID N. MIGDAL D.C
10345 SOUTHERN BLVD
ROYAL PALM BEACH, FL 33411
(561) 790-6388

PRINT NAME(S) OF DOCTOR(S) TREATING THIS PATIENT:

DR. DAVID N. MIGDAL, D.C.

_____

SOUTHERN CHIROPRACTIC LIFE CENTER

PATIEN NAME: _____ **DATE:** _____

INSTRUCTION: THESE QUESTIONS ASK FOR YOUR VIEWS ABOUT HOW YOUR PAIN AFFECTS HOW YOU FUNCTION IN EVERYDAY ACTIVITIES. PLEASE ANSWER EVERY QUESTION AND MARK **ONE** NUMBER ON **EACH** SCALE THAT BEST DESCRIBES HOW YOU FEEL.

DOES YOU PAIN INTERFERE WITH YOUR NORMAL WORK INSIDE AND OUTSIDE THE HOME?

WORK NORMALLY — UNABLE TO WORK AT ALL

0 1 2 3 4 5 6 7 8 9 10

DOES YOU PAIN INTERFERE WITH PERSONAL CARE (SUCH AS WASHING, DRESSING, ETC.)?

TAKE CARE OF MYSELF COMPLETELY — NEED HELP WITH ALL MY PERSONAL CARE

0 1 2 3 4 5 6 7 8 9 10

DOES YOU PAIN INTERFERE WITH YOUR TRFAVELING?

TRAVEL ANYWHERE I LIKE — ONLY TRAVEL TO SEE DOCTOR

0 1 2 3 4 5 6 7 8 9 10

DOES YOUR PAIN AFFECT YOUR ABILITY TO SIT OR STAND?

NO PROBLEMS — CANNOT SIT/STAND AT ALL

0 1 2 3 4 5 6 7 8 9 10

DOES YOUR PAIN AFFECT YOUR ABILITY TO LIFT OVERHEAD, GRASP OBJECTS, OR REACH FOR THINGS?

NO PROBLEMS — CANNOT DO AT ALL

0 1 2 3 4 5 6 7 8 9 10

DOES YOUR PAIN AFFECT YOUR ABILITY TO LIFT OBJECTS OFF THE FLOOR, BEND, STOOP, OR SQUAT?

NO PROBLEMS — CANNOT DO AT ALL

0 1 2 3 4 5 6 7 8 9 10

DOES YOUR PAIN AFFECT YOUR ABILITY TO WALK OR RUN?

NO PROBLEMS — CANNOT WALK/RUN AT ALL

0 1 2 3 4 5 6 7 8 9 10

HAS YOUR INCOME DECLINE SINCE YOUR PAIN BEGAN?

NO DECLINE — LOST ALL INCOME

0 1 2 3 4 5 6 7 8 9 10

DO YOU HAVE TO TAKE PAIN MEDICATION EVERY DAY TO CONTROL YOUR PAIN?

NO MEDICATION NEEDED — ON PAIN MEDICATION THOUGHOUT THE DAY

0 1 2 3 4 5 6 7 8 9 10

DOES YOUR PAIN FORCE YOU TO SEE DOCTORS MUCH MORE OFTEN THEN BEFORE YOUR PAIN BEGAN?

NEVER SEE DOCTORS — SEE DOCTORS WEEKLY

0 1 2 3 4 5 6 7 8 9 10

DOES YOU PAIN INTERFERE WITH YOUR ABILITY TO SEE THE PEOPLE WHO ARE IMPORTANT TO YOU AS MUCH AS YOU WOULD LIKE?

NO PROBLEM — NEVER SEE THEM

0 1 2 3 4 5 6 7 8 9 10

DOES YOU PAIN INTERFERE WITH RECREATIONAL ACTIVITIES AND HOBBIES THAT ARE IMPORTANT TO YOU?

NO INTERFERENCE — TOTAL INTERFERENCE

0 1 2 3 4 5 6 7 8 9 10

DO YOU NEED THE HELP OF YOUR FAMILY AND FRIENDS TO COMPLETE EVERYDAY TASKS (INCLUDING WORK OUTSIDE THE HOME AND HOUSEWORK) BECAUSE OF YOUR PAIN?

NEVER NEED HELP — NEED HELP ALL THE TIME

0 1 2 3 4 5 6 7 8 9 10

DO YOU NOW FEEL MORE DEPRESSED, TENSE, OR ANXIOUS THAN BEFORE YOUR PAIN BEGAN?

NO DEPRESSION/TENSION — SEVERE DEPRESION/TENSION

0 1 2 3 4 5 6 7 8 9 10

ARE THERE EMOTIONAL PROBLEMS CAUSED BY YOUR PAIN THAT INTERFERE WITH YOUR FAMILY, SOCIAL, AND/OR WORK ACTIVITIES?

NO PROBLEMS — SEVERE PROBLEMS

0 1 2 3 4 5 6 7 8 9 10

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DIRECT PAYMENT AUTHORIZATION WITHOUT ASSIGNMENT OF BENEFITS

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I HEREBY INSTRUCT AND DIRECT THE _____INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO:

SOUTHERN CHIROPRACTIC LIFE CENTER
DR, DAVID N. MIGDAL D.C
10345 SOUTHERN BLVD
ROYAL PALM BEACH, FL 33411

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO MEAND MAIL AS FOLLOWS:

C/O:
SOUTHERN CHIROPRACTIC LIFE CENTER
10345 SOUTHERN BLVD
ROYAL PALM BEACH, FL 33411

THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. **THIS IS A DIRECT PAYMENT AUTHORIZATION AND NOT AN ASSIGNMENT OF BENEFITS.** THIS 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 SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN THIS CASE.

DATED:_____

SIGNATURE OF POLICYHOLDER:_____

SIGNATURE OF CLAIMANT IF OTHER THEN POLICYHOLDER:_____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

PICA

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. RESERVED FOR NUCC USE
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code)	
ZIP CODE / TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. NPI b.	a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

MB-0D3W-M7PA

PLEASE PRINT OR TYPE

CR061657

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD

ENVELOPE BSS-02588-024