



Dr. Jeffrey S. Solomon

PATIENT INFORMATION

Date: _____ Sex: M F Marital Status: Single Married Other

Name: _____ Birthdate: ___/___/___ Social Security #: _____

Address: _____ Apt _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Ext: _____

Cell Phone () _____ E-mail address: _____

Employed Student Employer Name _____

Referred By: _____

Have you had chiropractic care in the past? Yes No If so, how long since last visit? _____

INSURANCE INFORMATION **PLEASE PROVIDE FRONT & BACK COPY OF CARD**

Person Insured: _____ Date of Birth: ___/___/___

Insured ID/File #: _____ Group #: _____

Insurance Co: _____ Insured's S.S. # _____ Insurance Co phone #: _____

HISTORY

Present Symptoms: _____

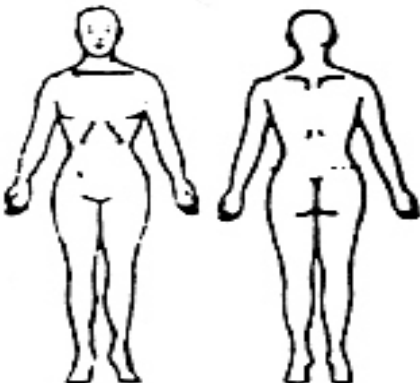
Illness/Disease: _____

Prior Surgery (s): _____

Previous Accidents, Traumas or Fractures: _____

(Mark Areas of Pain Below)

Are You Taking Any Medications? Yes No If so, please list:



Exercise? Type and Frequency _____

Work Duties : Lifting, Bending, Standing, Sitting, Computers, Driving (circle)

Circle the severity of the pain on a scale from 1 (least) to 10 (severe)

1 2 3 4 5 6 7 8 9 10

****PLEASE MAKE SURE TO READ & SIGN THE BACK OF THIS FORM****

AUTHORIZATION AND RELEASES

PATIENT NAME: _____ **DATE OF BIRTH:** _____

1. CONSENT FOR TREATMENT

I, the undersigned, hereby authorize, Dr. Jeffrey S. Solomon and whomever he/she may designate as his/her assistant (s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained. I, understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's Signature _____ **Date** _____ **Witness** _____

2. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ **Date** _____ **Witness** _____

3. REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: **Mobile Chiropractic 13865 South Dixie Highway Suite 307, Miami FL 33176.** The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ **Date** _____ **Witness** _____

4. ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient am directing my Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is non-contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on current status.

Patient's Signature _____ **Date** _____ **Witness** _____

5. CONSENT FOR TREATMENT OF MINOR

I hereby authorize **Jeffrey S. Solomon, D.C.** and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child) _____
child's name) _____

Guardian's Signature _____ **Date** _____ **Witness** _____

6. X-RAY/MEDICAL RECORDS RELEASE

I have requested the release of records of (patient's name) _____
Which are a part of the records at (facility) _____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to:

(Name): _____

(Address): _____

Patient's Signature _____ **Date** _____ **Witness** _____