



**Dr. David J. Dorfman**

**PATIENT INFORMATION**

Date: \_\_\_\_\_ Sex: M  F  Marital Status: Single  Married  Other

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

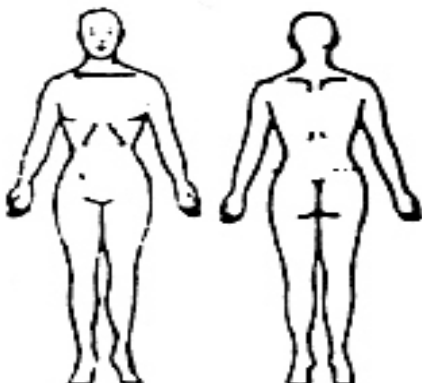
Illness/Disease: \_\_\_\_\_

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. David J. Dorfman 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 9291 Nugent Trail, West Palm Beach, FL. 33411.** 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 **David J. Dorfman, 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** \_\_\_\_\_