Oceanside Wellness Center
Dr. Lee Weiner, D.C.
9 Davison Ave, Oceanside NY 11572 – (516) 255-0272

TELL US ABOUT YOU **(PLEASE PRINT CLEARLY)**

NAME:		SOCIAL SECURITY #:		DATE:
DATE OF BIRTH:	AGE:	SEX: M F	MARITAL STATUS: M S D W	# OF CHILDREN:
ADDRESS:				
CITY:		STATE:		ZIP:
HOME PHONE #:		CELL PHONE #:		
E-MAIL ADDRESS:		OCCUPATION:		
COMPANY NAME:		LENGTH OF EMPLOYMENT:		
TYPE OF WORK:	OFFICE/CLERICAL	LIGHT LABOR	MODERATE LABOR	HEAVY LABOR
SPOUSES NAME:				
IN CASE OF EMERGENCY CONTACT NAME:		HOME PHONE #:		

TELL US ABOUT YOUR PAST HEALTH

Y	N	← Frequent Neck Pain	Y	N	← Alcohol / Drug	Y	N	← Stroke
Y	N	← Lower Back Pain	Y	N	← Hepatitis	Y	N	← Heart Surgery / Pacemaker
Y	N	← Severe / Frequent	Y	N	← HIV / Aids	Y	N	← Heart Murmur
Y	N	← Fainting / Seizures /	Y	N	← Shingles	Y	N	← Congenital Heart Defect
Y	N	← Arm / Leg Pain	Y	N	← Cancer	Y	N	← Mitral Valve Prolapse
Y	N	← Arthritis	Y	N	← Chemotherapy	Y	N	← Artificial Valves
Y	N	← Artificial Limbs /	Y	N	← Anemia	Y	N	← Rheumatic Fever
Y	N	← Asthma / Emphysema	Y	N	← Difficulty Breathing	Y	N	← Diabetes / Tuberculosis
Y	N	← Ulcers / Colitis	Y	N	← Psychiatric Problems	Y	N	← High / Low Blood Pressure
Y	N	← Kidney Problems	Y	N	← Heart Attack	Y	N	← Fractures
Y	N	← Workers Comp	Y	N	← Personal Injuries	Y	N	← Sports or Other Injuries to Head, Neck or Back
Y	N	← Hospitalized	Y	N	← Chiropractic Care	Y	N	← Surgery

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:
PLEASE LIST ANY VITAMINS YOU ARE CURRENTLY TAKING:
PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS YOU HAVE EVER HAD:

PRIMARY CARE PHYSICIAN:	PHONE #:
DATE OF LAST DOCTOR VISIT:	
LIST ANY THING YOU MAY BE ALLERGIC TO:	
LIST PAST SERIOUS ACCIDENTS:	

FAMILY HEALTH HISTORY:	DIABETES	CANCER	HEART DISEASE / STROKE	OTHER:
DO YOU SMOKE? Y N	HOW LONG?		PACKS PER DAY:	
ALCOHOL CONSUMPTION?	NEVER	SOCIAL	LIGHT	MODERATE	HEAVY

FOR WOMEN ONLY

DO YOU TAKE BIRTH CONTROL?	Y	N	IF YES, FOR HOW LONG?				
ARE YOU NURSING?	Y	N	ARE YOU PREGNANT	Y	N	DELIVERY DATE?	

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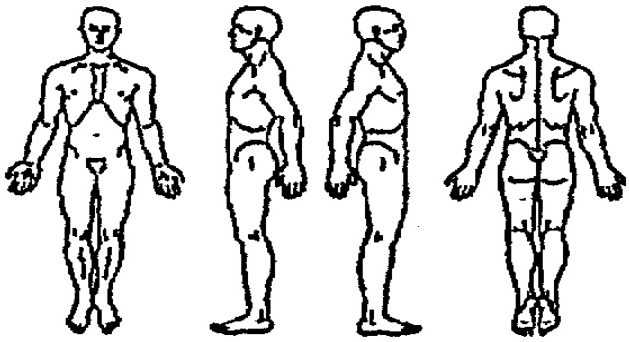
Name _____REASON FOR THIS VISIT Date_____

THE REASON FOR THIS VISIT IS A RESULT OF (PLEASE CIRCLE):	AUTO ACCIDENT	WORK INJURY	TRAUMA	SPORTS
	GRADUAL ONSET	CHRONIC	OTHER	
DATE OF INJURY / WHEN DID THE CONDITION BEGIN?				
IS THE CONDITION GETTING WORSE?	Y	N		
EXPLAIN WHAT HAPPENED:				

IS THIS CONDITION INTERFERING WITH YOUR (PLEASE CIRCLE):	WORK	SLEEP	DAILY ROUTINE	OTHER:
IF SO, PLEASE EXPLAIN:				

Please darken the body part(s) in which you are currently experiencing symptoms:



CHIEF COMPLAINTS

	Where does it hurt?	ONSET (When did the pain start?)	PROVOCATIVE (What makes it worse?)	PALLIATIVE (What makes it better?)	QUALITY (Achy, stiff, sharp, burning, etc.)	RADIATION (Does the pain go down your arm / leg?)	SEVERITY (1 – 10)	TEMPORAL (When does it hurt? Constant, On and off)
1.								
2.								
3.								
4.								
5.								

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AUTHORIZATIONS: Name:_____ Date:_____

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment of this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident 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. 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. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. Unpaid balance of more than 90 days will be turned over to a collections agency.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT**:**	
INSURANCE COMPANY:	PHONE #:
GROUP #:	ID #:

Signature_____ **Date** _____

Guardian Signature_____ **Date** _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?