## Peter J. Stein, DC •• Chiropractic Physician

#### **WELCOME!**

In order to provide you with the best possible care, please provide the information below.

## PAYMENT INFORMATION

133 Brookline Ave. ••Boston, MA 02215

Unless other arrangements have been made, payment would be appreciated at the time that services are rendered.

# PATIENT IDENTIFICATION Occupation: Name Male [] Female [] Street Date of Birth:\_\_\_\_\_ Age:\_\_\_\_ City, State, and Zip Medicare ID no.\_\_\_\_\_ Other insurance co.:\_\_\_\_\_ ID: **Contact numbers:** best #? Who referred you to this office? ☐ Home: (\_\_\_\_)\_\_\_\_\_ □ Work: (\_\_\_)\_\_\_\_ May we thank them? []yes []no Mobile: ( ) Contact in case of emergency: *Telephone:*(\_\_\_\_)\_\_\_\_ Name of parent/guardian of Minor Patient:\_\_\_\_\_ Following your completion of these forms, a history and physical examination will be conducted, to further determine your health needs. In the event that your needs cannot be met here, this office will refer you to another health care provider, if appropriate. Your signature below will authorize payment to us by a third party, if applicable, for covered services we perform. You are ultimately responsible for payment of expenses related to your care in this office. This includes a fee for missed appointments, as well as for cancellations less than 12 hours in advance of the appointment time. *Please sign below to indicate your understanding of the above paragraph:* Signature Date

phone:(617) 232-3927

fax:(617) 421-6406

Name	□ Initial	☐ Re-evaluation

Please indicate areas where you experience pain, using the body outlines below. Please mark the quality of the pain, using the suggested code letters, or other indicators you prefer.

A = ache

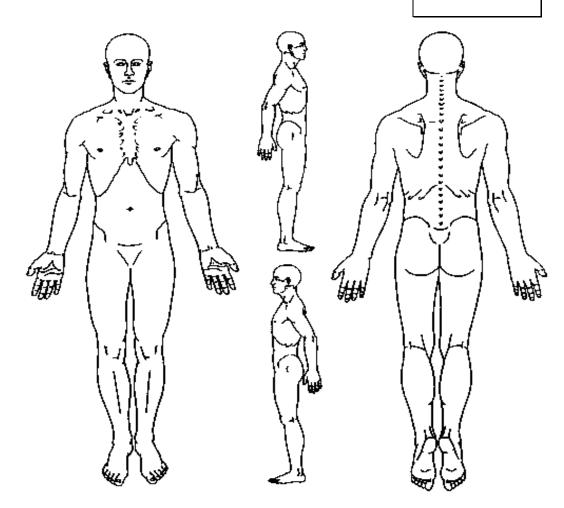
B = burning

N = numbness

P = pins and needles

 $S = \frac{1}{sharp/stabbing}$ 

X= other



Please mark your level of pain anywhere on the line below:

no worst possible pain pain

## **HEALTH HISTORY**

Please list all allergies (foods, drugs, environment).  When was  your last physical exam?  Primary doctor: Phone Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:  PAST MEDICAL HISTORY  Do you have, or have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)  measles  no yes migraine mimps no yes headaches no yes headaches no yes chickenpox no yes cough no yes cough no yes pollio no yes plolio pno yes pneumonia no yes glaucoma no yes plolio present health concerns, symptoms, or problems you are experiencing:  PAST MEDICAL HISTORY  Do you have, or have you ever had the following: (Circle "no" or "yes", leave blank if uncertain) measles no yes headaches no yes multiple whooping diabetes no yes sclerosis no yes diabetes no yes prolapse no yes pneumonia no yes glaucoma no yes pneumonia no yes plodo or plasma ulcer no yes heart disease no yes blood or plasma ulcer no yes heart disease no yes blood or plasma ulcer no yes heart disease no yes back trouble no yes sexually trans- high/low blood mitted disease no yes anemia no yes hearesion no yes hedericsion no yes bladder infection no yes hives/eczema no yes Any other disease/disorder?	PATIENT NAMEBIRT					THDATE				
Today's date	This history	form p	orovides us wi	th information to help us	meet	all your healthc	are needs. This is a con	fidenti	al part of	
Place of Birth   hospitalizations you have experienced and indicate year thighest level in school   Occupation   Previous occupations   Marital status   Hobbies   Exercise/recreation   Smoking (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)   Please list all medicines you are currently taking (include nonprescription drugs):  Any history of family/partner violence?   Any history of famil	your medic	al rec	ord.							
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Place of Birth   hospitalizations you have experienced and indicate year these occurred:    Cocupation	Today's date									
Occupation  Previous occupations  Marital status  Hobbies  Exercise/recreation  Smoking (type & amount per day)  Alcohol (type & amount per day)  Usual weight  Date of last dental exam  Please list all medicines you are currently taking (include nonprescription drugs):  Alcohol (type & amount per day)  Usual weight  My ideal weight  Date of last dental exam  Please list all lallergies (foods, drugs, environment)  When was your last physical exam?  Primary doctor:  Phone  Any history of family/partner violence?  PAST MEDICAL HISTORY  Do you have, or have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)  measles no yes migratine measles no yes headaches no yes bronchitis no yes chickenpox no yes tuberculosis no yes miltral valve diabetes no yes sclerosis no yes cough no yes cancer no yes mitral valve diphtheria no yes polio no yes prolapse no yes prolapse no yes prolapse no yes heading no yes h	Place of Birth									
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#### Consent for Use or Disclosure of Health Information

## Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

## Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

## Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

• I have read your consent police of this notice.	cy and agree to its terms. I a	am also acknowledging that I have received a copy
	OR OR	authorized personal representative
signature		date
date		