OFFICE OF DR. HOBIE FURSHMAN

PLEASE PRINT

GENERAL INFORMATION:

PATIENT LAST NAME_____FIRST NAME_____

GUARDIAN (IF APPLICABLE) LAST NAME_____ FIRST NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

DATE OF BIRTH____/_____/_____ SOCIAL SECURITY NUMBER_____/_____/_____

SEX M F MARRIED / SINGLE / WIDOWED / DIVORCED

PHONE (CELL) _____PHONE (HOME)_____

E-MAIL ADDRESS_____

WHO REFERRED YOU TO US?_____

CHIEF COMPLAINT _____

RELEASE AND ASSIGNMENT X_____

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

FOR WOMEN (NON PREGNANCY VERIFICATION)

I HEREBY NOTIFY ALL CONCERNED, THAT I NEITHER SUSPECT NOR KNOW POSITIVELY AT THIS TIME THAT I MAY BE PREGNANT. I RELEASE THIS CLINIC FROM ANY AND ALL DAMAGES ARISING FROM ANY AND ALL PROCEDURE OF DIAGNOSTIC XRAYS OR TREATMENT NATURE WITH REFERENCE TO THE POSSIBILITY OF PREGNANCY.

PATIENT SIGNATURE _____ DATE: _____

Family History

Because of "health" and "lack of health" is passed down within one's family, please circle any familiar illnesses.

SPOUSE: Headaches/Migraines/Neck Pain/Low Back Pain/ Pain or Numbness of the Hands or Feet/Arm Pain/ Leg Pain/Menstrual Cramps/Scoliosis/Cancer/Stroke/Diabetes/ Heart Attack/Heart Disease/Other _____

FATHER: Headaches/Migraines/Neck Pain/Low Back Pain/ Pain or Numbness of the Hands or Feet/Arm Pain/ Leg Pain/Scoliosis/Cancer/Stroke/Diabetes/Heart Attack/ Heart Disease/Other _____

MOTHER: Headaches/Migraines/Neck Pain/Low Back Pain/ Pain or Numbness of the Hands or Feet/Arm Pain/ Leg Pain/Menstrual Cramps/Scoliosis/Cancer/Stroke/Diabetes/ Heart Attack/Heart Disease/Other _____

SON: Headaches/Scoliosis/Asthma/Allergies/Digestive Disorder/ Constipation/Ear Infections/Attention Deficit Disorder/ Hyperactivity/Autism/Chronic Colds/Cancer/Diabetes/ Other _____

DAUGHTER: Headaches/Scoliosis/Asthma/Allergies/Digestive Disorder/ Constipation/Ear Infections/Attention Deficit Disorder/ Hyperactivity/Autism/Chronic Colds/Cancer/Diabetes/ Menstrual Cramps/Other _____

HIPPA form (Privacy Act Notification)

Furshman and Davis Chiropractic Centers

This form states that I _____ have read
(Print your name)
and understood the HIPPA (Health Insurance Portability and Accountability Act) notice on _____.
(Date)

X _____
(Patient Signature)

X _____
(Staff Signature)

OFICINA DE DR. HOBIE FURSHMAN

POR FAVOR IMPRIMIR

INFORMACION GENERAL:

PACIENTE APELLIDO_____ PRIMER NOMBRE_____

GUARDIAN (SI APLICA) APELLIDO_____PRIMER NOMBRE_____

DIRECCIÓN_____

CIUDAD_____ ESTADO_____ CODIGO POSTAL_____

FECHA DE NACIMIENTO_____/_____/_____ NÚMERO DE SEGURO SOCIAL _____/_____/_____

SEXO M F CASADO / SOLTERO(A) / VIUDO / DIVORCIADO

TELÉFONO (CELULAR) _____TELÉFONO (CASA) _____

DIRECCIÓN DE CORREO ELECTRÓNICO_____

QUIEN LO REFIRIO A NOSOTROS? _____

QUEJA PRINCIPAL_____

LANZAMIENTO Y ASIGNACIÓN X_____

Autorizo la divulgación de toda la información necesaria para procesar las reclamaciones de mi seguro y asignar y solicitar el pago directamente a mis médicos.

PARA MUJERES (VERIFICACIÓN DE NO EMBARAZO)

POR LA PRESENTE, NOTIFICO A TODOS LOS INTERESADOS, QUE NO SOSPECHO NI CONOCÉ POSITIVAMENTE EN ESTE MOMENTO QUE PUEDA ESTAR EMBARAZADA. LIBERO ESTA CLÍNICA DE CUALQUIERA Y TODOS LOS DAÑOS QUE SURJAN DE CUALQUIER Y TODOS LOS PROCEDIMIENTOS DE LAS RADIACIONES DE DIAGNÓSTICO O LA NATURALEZA DEL TRATAMIENTO CON REFERENCIA A LA POSIBILIDAD DE EMBARAZO.

FIRMA _____ FECHA_____