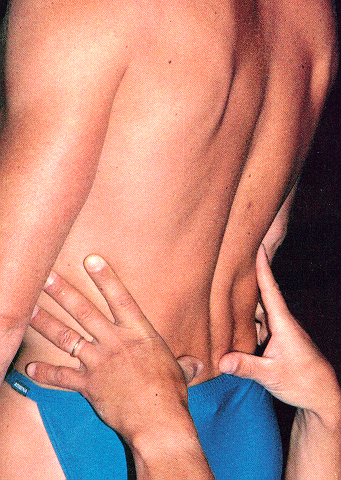
## **DuBarry Chiropractic, Inc.**

**Patient General**

**Information**

**CONFIDENTIAL**



11211 Prosperity Farms Road

Suite B204

Palm Beach Gardens, Fl 33410 USA

Tel: 561-622-9197

Fax: 561-622-4964

[www.dubarrychiropractic.com](http://www.dubarrychiropractic.com)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Ph \_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Ph \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pager \_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who sent you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical Body Position at Work: 🞎 Varies 🞎 Sitting 🞎 Standing 🞎 Others Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated by a Chiropractor before? 🞎 Yes 🞎 No

Have you seen a Physical Therapist before? 🞎 Yes 🞎 No

Spouse Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you covered by Medicare? 🞎 Yes 🞎 No Your Insurance co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your deductible been met, if any? 🞎 Yes 🞎 No 🞎 I don’t know

I do not have insurance & prefer to pay out-of-pocket. 🞎 Yes 🞎 No

Condition is due to a work accident? 🞎 Yes 🞎 No

Have you had a recent trauma? 🞎 Yes 🞎 No

Have you had a car accident in the past? 🞎 Never 🞎 Month 🞎 Year 🞎 Over 2 years

When was your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

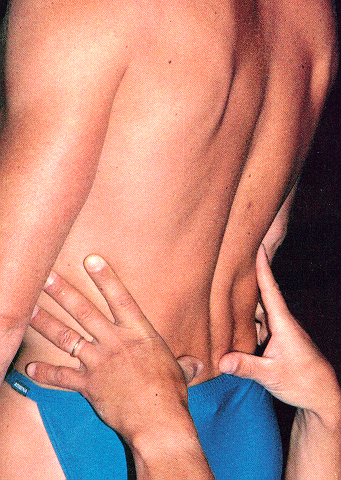
Do you have a treating Physician? 🞎 Yes 🞎 No Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an Urologist or OBGYN? 🞎 Yes 🞎 No Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Form**  **Confidential** | | | | | | | | | | | |
| **Last Name** |  | | **First Name** | | |  | | | | **Today’s Date** |  |
| **Do you have or have you ever had any of the following?** | | | | | | | | | | | |
| 🞎 Alcoholism  🞎 Anemia  🞎 Cancer  🞎 Canker Soars  🞎 Diabetes  🞎 Epilepsy  🞎 Goiter | | 🞎 Gout  🞎 Hypoglycemia  🞎 Multiple sclerosis  🞎 Osteoarthritis  🞎 Parkinson’s disease  🞎 Pneumonia  🞎 Polio | | | | | 🞎 Rheumatic fever  🞎 Rheumatoid Arthritis  🞎 Ulcers | | | | |
| **What is the health history of your immediate family?** | | | | | | | | | | | |
| Mother…………………………………………………………………………………………………  Father…………………………………………………………………………………………………  Grandparents…………………………………………………………………………………………………  Brothers…………………………………………………………………………………………………  Sisters…………………………………………………………………………………………………  Children………………………………………………………………………………………………… | | | | | | | | | | | |
| What is your resistance to infections?  🞎 Catch Cold Easily 🞎 Have Frequent Sinus Trouble 🞎 Your Gums Bleed Easily | | | | | | | | | | | |
| **System Review** | | | | | | | | | | | |
| **Gastrointestinal**: Do you or have you experienced? | | | | | | | | | | | |
| 🞎 Constipation  🞎 Blood in Stool  🞎 Distress From Fat  🞎 Nausea  🞎 Heartburns  🞎 Burning of the stomach relieved by eating  🞎 Burping or Bloating | | | | | | | 🞎 Diarrhea  🞎 Metallic taste in mouth  🞎 Hiatal hernia  🞎 Vomiting  🞎 Recent Weight Gain  🞎 Recent Weight Loss | | | | |
| **Cardiovascular**: Do you or have you experienced? | | | | | | | | | | | |
| 🞎Pain in the heart  🞎Heart Attack  🞎Swelling in Ankles  🞎Irregular Heartbeat  🞎Stroke | | | 🞎Shortness of Breath in exertion  🞎Low Blood Pressure  🞎High Blood Pressure  🞎Pressure in the Chest | | | | | | | | |
| **Nervous System:** Do you or have you experienced? | | | | | | | | | | | |
| 🞎 Dizziness/ lightheaded  🞎 Fainting | | | 🞎 Memory loss  🞎 Loss of coordination | | | | | | | | |
| **Eye, Ear, Nose and Throat**: Do you or have you experienced? | | | | | | | | | | | |
| 🞎 Vision Problems  🞎 Hearing Loss  🞎 Ear Pain  🞎 Ear Noises  🞎 Dental Problems  🞎 Nose Bleeding | | | 🞎 Difficulty Breathing Through Nose  🞎 Difficult Speech  🞎 Hoarseness  🞎 Sore Throat | | | | | | | | |
| **Urinary Tract:** | | | | | | | | | | | |
| 🞎 Blood in Urine  🞎 Inability to Control Urination  🞎 Painful Urination | | | 🞎 Bladder Infection  🞎 Kidney Stones | | | | | | | | |
| **Respiratory** | | | | | | | | | | | |
| 🞎 Chest Pain  🞎 Spitting up Blood  🞎 Spitting up Phlegm | | | 🞎 Difficulty Breathing  🞎 Shortness of Breath  🞎 Emphysema | | | | | 🞎 Allergies  🞎 Asthma  🞎 Chronic Cough | | | |
| **Women only:** | | | | | | | | | | | |
| 🞎 Irregular period  🞎 Menopausal Symptom  🞎 Vaginal Discharge  🞎 Lumps in Breast  🞎 Premenstrual Depression | | | 🞎 Hot Flashes  🞎 Menstrual cramps  🞎 Excessive flow  🞎 Painful Breast | | | | | | 🞎 Nausea  🞎 Spotting  🞎 Hysterectomy  🞎 Headaches with Period | | |
| **Men only** | | | | | | | | | | | |
| 🞎 Burning on Urination  🞎 Difficulty Starting Urination  🞎 Need to get up at Night to Urinate | | | | 🞎 Feeling of Incomplete Bowel Evacuation  🞎 Prostate Trouble  🞎 Dripping after Urination | | | | | | | |
| **List All the Surgeries You Have Had And List The Dates** | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **List Any Medication You Are Now Taking** | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Do You Smoke?** 🞎 **Yes** 🞎 **NO** | | | | | **How many packs a day……….**  **For how many years…………** | | | | | | |
| **What is Your Alcohol Intake?** | | | | | | | | | | | |
| **Patient’s signature** | | | | | | | | | | | |

Area of complaint (initial visit)



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last name |  | First name |  | Today’s date |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A Circle Each Area of Complaint on the Chart Below**  humanbody | | | | | | | | B Please answer the following questions about each area of pain you circled. If there is more than one area please number each area and fill out the additional sections. Sign and date on back.   |  |  |  |  | | --- | --- | --- | --- | | Area # |  | | | | Pain Number (O none to 10 worst) | | |  | | What makes your pain feel worse? | |  | | | What makes your pain feel better? | |  | | | How long after the accident before the symptoms developed? | |  | | | Do you have pain (circle) | | 25% 50% 75% 100% of the day? | | | How many days a week do you have pain? | |  | | | Have you had prior complains in this area? | | Yes No | | | If yes to the precedent questions explain | |  | | | | | | |
| **C**  Area # |  | Pain Number (O none to 10 worst) | | | | | | |  | |  | |
| What makes your pain feel worse? | | | | | |  | | | | | | |
| What makes your pain feel better? | | | | |  | | | | | | | |
| How long after the accident before the symptoms developed? | | | | | | | | | |  | | |
| Do you have pain (circle) | | | 25% 50% 75% 100% of the day? | | | | | | | | | |
| How many days a week do you have pain? | | | |  | | | Have you had prior complains in this area? | | | | | Yes No | |
| If yes to the precedent questions explain | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **DuBarry Chiropractic Inc****Dr. E. DuBarry** 11211 Prosperity Farms Rd.  Suite B 204  Palm Beach Gardens  FL 33410 U.S.A.  **Tel**: (561) 622-9197  **Fax**: (561) 622 –4964  **E-Mail**: drdubarry@comcast.net | **OFFICE POLICY** |

**Dear Sir or Madam:**

**Our office policy is dedicated to your health. We have created this office policy to prevent misunderstandings**.

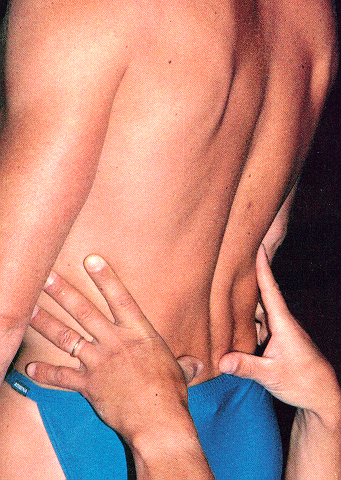
1. For the first visit:

* If you carry regular health insurance and your coverage could not be verified right away, you need to pay the first visit in full then the co-pay on next visits. The money will be refunded with a check or will be applied towards your future co-pays when the first payment is received from the insurance company
* If you are a cash patient you pay your visits in full.

1. Most insurance plans don’t pay for chiropractic services. If your insurance qualifies, we will bill your insurance company directly. However, all charges are your responsibility from the date the services are rendered. **(**If you are a Medicare, an automobile accident or a work injury patient this does not apply for you.). However, please note that this office provides many additional services in addition to manual manipulations that may not be covered by your insurance. The front desk has additional information about insurance company billing upon request.
2. In order to maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees.
3. Collections: WHAT YOUR INSURANCE COMPANY DOES NOT PAY WITHIN 60 DAYS YOU MUST PAY. If collection proceedings become necessary, the patient or the one responsible for the payment, agree to be responsible for all attorney fees, court costs, or any other fees in the collection of debt.
4. Interest charge of 10% per year, will be added each month, to all 30 days past due accounts.
5. **CANCELLATION OF APPOINTMENT MUST BE GIVEN 24 HOURS IN ADVANCE TO AVOID BEING CHARGED. NO-SHOW OR SAME DAY CANCELLATION FEE IS $25.00**
6. I have read, understood and agreed to all of the above information.

Patient’s signature ------------------------------------------------------------Date:---------------------------

## DuBarry Chiropractic Inc



## Dr. Etienne DuBarry

11211 Prosperity Farms Rd.

Suite B 204

Palm Beach Gardens

FL 33410 U.S.A.

**FINANCIAL POLICY**

**Tel**: (561) 622-9197

**Fax**: (561) 622 –4964

**E-Mail**:drdubarry@comcast.net

Filing your insurance claims is a courtesy we extend to our patients and does not relieve you of the responsibility of your bill. Patients are responsible for payment of deductibles, co-payments or any other procedures that are not covered under the insurance contract. Payment is expected at the time of the visit. Billing department files your claims to your primary insurance company, therefore filing your medical claims to your secondary insurance company is solely your responsibility.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASSIGNMENT OF BENEFITS: I authorize payments of benefits to Dr. Etienne DuBarry for any service rendered.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process my insurance claims.

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

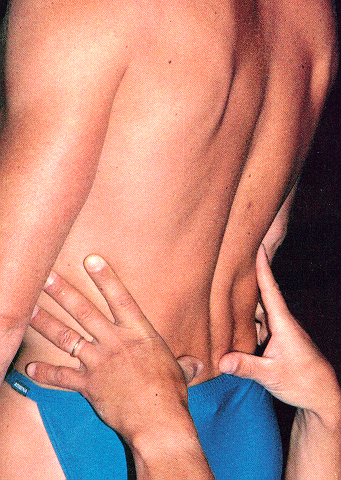
I understand and agree that I am responsible for the balance on my account for any professional services rendered, and I will notify this office of any changes in my insurance status.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please present your insurance card and a picture I.D. to the office staff.

## DuBarry Chiropractic Inc

**NOTICE OF PRIVACY PRACTICES**



## Dr. Etienne DuBarry

11211 Prosperity Farms Road

Suite B 204

Palm Beach Gardens

FL., 33410 U.S.A.

**Tel**: (561) 622-9197

**Fax**: (561) 622-4964

**E-Mail**:drdubarry@comcast.net

I have reviewed and understood Dr. Etienne DuBarry, D.C. Notice of Privacy Practices which describes how medical information about myself, or the patient that I am the representative of, may be used or disclosed and how I can get access to this information.

PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT I AM REPRESENTING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

………..I have read the Notice of Privacy Practices and refuse a hard copy at this time. I may request a hard copy at a later date.

Request copy of Notice of Privacy Practices:

.............Paper copy given in office.

………..US Mail to Address……………………………………….

………………………………………………………………………..