Rothman Chiropractic & Wellness Center, LLC

Dr. Danielle Rothman, DC, FIPCA
510 Sylvan Ave, Suite 203
Englewood Cliffs, NJ 07632
Phone: 201.569.7004
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NEW PATIENT FORM

PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: ____

Zip Code: _____

Email: _____

Sex: ☐ M ☐ F Age: ___ Birthday: _____

SSN/Patient ID: _____

Status:

Occupation: _____

Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: _____

Spouse's Name: _____

Birthday: _____ SSN: _____

Employer: _____

INSURANCE

Insurance Company: _____

Group Number: _____

Who is responsible for this account? _____

Is patient covered by additional insurance? ☐ Y ☐ N

Subscriber's Name: _____

Birthday: _____ SSN: _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

_____

and assign directly to Dr. Danielle Rothman, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Print Name of Patient, Parent, Guardian, or Personal Representative Date

PHONE NUMBERS

Home: _____ Cell: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Phone: _____

ACCIDENT INFORMATION

Is condition due to accident? ☐ YES ☐ NO

Type of accident: _____

To whom have you made a report of the accident?

_____

Attorney Name (if applicable):

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PATIENT CONDITION

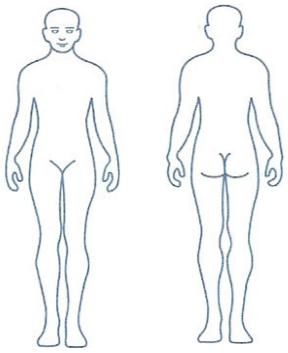
Reason for visit:

When did your symptoms appear?

Is this condition getting progressively worse? ☐ YES ☐ NO ☐UNKNOWN

Rate the severity of your pain on a scale from 1 (least) to 10 (severe):

Mark an X on the picture where you continue to have pain, numbness, or tingling



Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Burning	☐ Tingling	☐ Cramps	☐ Stiffness
☐ Aching	☐ Swelling	☐ Shooting	☐ Other:

How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition?

☐ Medications ☐ Surgery
☐ Physical Therapy ☐ Chiropractic Services
☐ None ☐ Other:

Date of last:

Physical Exam:	Spinal X-Ray:	Blood Test:
Spinal Exam:	Chest X-Ray:	Urine Test:
Dental X-Ray:	MRI/CT Scan/Bone Scan:	

Are you pregnant? ☐ YES ☐ NO Due Date: _____

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HEALTH HISTORY (CONTINUED)

Place a mark on "YES" or "NO" if to indicate if you have had any of the following:

AIDS/HIV	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Alcoholism	☐ YES	☐ NO	Emphysema	☐ YES	☐ NO	Measles	☐ YES	☐ NO	Scarlet fever	☐ YES	☐ NO
Allergy Shots	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO	Migraines	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Fractures	☐ YES	☐ NO	Miscarriage	☐ YES	☐ NO	Suicide Attempt	☐ YES	☐ NO
Anorexia	☐ YES	☐ NO	Glaucoma	☐ YES	☐ NO	Mononucleosis	☐ YES	☐ NO	Thyroid Problems	☐ YES	☐ NO
Appendicitis	☐ YES	☐ NO	Goiter	☐ YES	☐ NO	Multiple Sclerosis	☐ YES	☐ NO	Tonsillitis	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	Gonorrhea	☐ YES	☐ NO	Mumps	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Gout	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO	Tumors, Growths	☐ YES	☐ NO
Chicken Pox	☐ YES	☐ NO	Heart Disease	☐ YES	☐ NO	Pacemaker	☐ YES	☐ NO	Typhoid Fever	☐ YES	☐ NO
Breast Lump	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO	Parkinson's Disease	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO
Bronchitis	☐ YES	☐ NO	Hernia	☐ YES	☐ NO	Pinched Nerve	☐ YES	☐ NO	Vaginal Infections	☐ YES	☐ NO
Bulimia	☐ YES	☐ NO	Herniated Disk	☐ YES	☐ NO	Pneumonia	☐ YES	☐ NO	Whopping Cough	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Herpes	☐ YES	☐ NO	Polio	☐ YES	☐ NO	Sexually Transmitted Infection	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO	High Cholesterol	☐ YES	☐ NO	Prostate Problem	☐ YES	☐ NO			
Chemical Dependency	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO	Prosthesis	☐ YES	☐ NO	Bleeding Disorders	☐ YES	☐ NO
			Kidney Disease	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO			

Other: _____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking: Packs/Day: _____

☐ Alcohol: Drinks/Week: _____

☐ Coffee/ Caffeine Drinks: Cups/Day: _____

☐ High Stress Level: Reason: _____

INJURIES/SURGERIES

Please describe below. Include appropriate dates.

MEDICATIONS

Please list any medications you take:

ALLERGIES

Please list any allergies you have:

VITAMINS/HERBS/MINERALS

Please list any vitamins/herbs/minerals you are taking: