

CONFIDENTIAL PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Social Security # _____ - _____ - _____ Gender ☐ Male ☐ Female Age: _____

Birthdate: _____ / _____ / _____ Marital Status ☐ Married ☐ Single ☐ Widowed

Address: _____

City: _____ State: _____ Zip: _____

Primary Ph. #: _____ Secondary Ph. #: _____

Email: _____

Occupation: _____ Employer: _____

Name of Spouse/Parent/Guardian (if applicable): _____

Spouse's Employer: _____ Spouse's Occupation: _____

EMERGENCY CONTACT

Name, Relation & Phone #: _____

Address (if different from patient): _____

How were you referred to this office?

☐ Friend/Family Member ☐ Google ☐ Our Website ☐ Billboard ☐ Yellow Pages

☐ Our Building Sign ☐ Primary Doctor ☐ Other (please explain) _____

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No (If yes, our receptionist will need a copy of your ins. card)

Please check one or more of the following for your insurance coverage:

☐ Private Insurance ☐ Workers Compensation ☐ Motor Vehicle Accident
☐ Medicare ☐ Medicaid ☐ Other

Insurance Company: _____

ID # or Claim #: _____

Insured's Name (if not the patient): _____

Patient Relationship to Insured: ☐ Spouse ☐ Parent ☐ Child

Please Note: Health and Accident insurance policies are in the arrangement between the carrier and the patient which are usually designed to offset a large of the total cost. This office will prepare any necessary reports and forms to assist in making collections from the insurance company to the patient or any amount authorized to be paid directly to this office will be credited to the patient's account. It should be understood that ALL services furnished are charged directly to the patient, who is personally responsible for payment. Payment is expected at the time of service, unless your insurance company covers chiropractic care at 100%. By signing below, I am agreeing that I fully understand I am responsible for all balances due.

Patient's Signature: _____ Date: _____ / _____ / _____

Check the symptoms you have experienced since the injury or illness began:

☐ Headaches	☐ Pins/Needles, Arms	☐ Buzzing in Ears
☐ Neck Pain	☐ Pins/Needles, Legs	☐ Loss of Balance
☐ Neck Stiffness	☐ Numbness, Fingers	☐ Fainting
☐ Back Pain	☐ Numbness, Toes	☐ Loss of Smell
☐ Nervousness	☐ Fatigue	☐ Loss of Taste
☐ Tension	☐ Depression	☐ Diarrhea
☐ Irritability	☐ Light Hurts Eyes	☐ Cold Feet
☐ Chest Pain	☐ Loss of Memory	☐ Cold Hands
☐ Dizziness	☐ Ringing in Ears	☐ Upset Stomach
☐ Head Feels Heavy	☐ Face Flushed	☐ Constipation
☐ Sleeping Problems	☐ Shortness of Breath	☐ Cold Sweats

ACCIDENT INJURY INFORMATION

Date of Accident: ____ / ____ / ____ Time: _____ AM or PM

The accident was: ____ Auto Collision ____ Job Injury ____ Other Injury

For **work related** injuries only

Was supervisor/employer informed? ____ Yes ____ No

Did your employer recommend care at this office? ____ Yes ____ No

For **auto accidents** only

You were the: ____ Driver ____ Passenger ____ Pedestrian

You were struck from: ____ Behind ____ Front ____ Right Side ____ Left Side

Did you need post-accident hospitalization? ____ Yes ____ No

If so, which hospital did you go to? _____

Were X-rays taken? ____ Yes ____ No

Have you lost days from work? ____ Yes ____ No

If you lost days from work, how many and which specific days?

Do you have an attorney advising you on this claim? ____ Yes ____ No

Name: _____ Phone #: _____

Address: _____

Insurance Claim #: _____

1. What is your primary complaint? _____
2. What is the location of the complaint? _____
3. When did the pain start? (try to be specific) _____
4. The pain was: ___ Gradual ___ Sudden
5. What type of pain is it? ___ Sharp ___ Dull ___ Ache ___ Shooting
 ___ Pressure ___ Burning ___ Numb ___ Pins/Needles
6. How long does it last? ___ Constant ___ On & Off ___ Hours ___ Minutes
7. How often do you have the pain? ___ Daily ___ Several times per week
 ___ Few Hours/Day ___ Several times per month
8. Does the pain travel or radiate to any other part of your body? If so, where?
___ Legs (Right or Left) ___ Arms (Right or Left) Other: _____
9. What aggravates the pain?
___ Sitting ___ Standing ___ Twisting ___ Bending
___ Walking ___ Sneezing ___ Sleeping ___ Coughing
Other: _____
10. What gives you relief? ___ Heat ___ Ice ___ Massage ___ Medication
Other (please describe): _____
11. Have you taken any medication in the past? ___ Yes ___ No
12. Are you presently taken medication? ___ Yes ___ No
If so, what medication and for what conditions? _____
13. Have you seen another Doctor for this condition? ___ Yes ___ No
If so, what is the Doctor's name and phone #? _____

- What was done for you at this office? _____
14. Have you had any recent surgery? ___ Yes ___ No If so, date & type? _____
15. Are you suffering from any other illness? If so, please describe: _____
16. What is the date of your last physical? _____
17. Is this your first chiropractic treatment? ___ Yes ___ No
If not, who were you seeing before? _____
18. Please indicate any further comments: _____

*Dr. Perry J. Cicchini.
Dr. Jeannine Cicchini
805 S. Black Horse Pike
Blackwood, NJ 08012*

ASSIGNMENT OF BENEFITS FORM

Patient's Name: _____

I irrevocably assign to Doctors Perry J. Cicchini and Jeannine Cicchini all my rights and benefits under any insurance contract for payment for services rendered to me by Doctors Perry J. Cicchini and Jeannine Cicchini. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by Doctors Perry J. Cicchini and Jeannine Cicchini to be release to Doctors Perry J. Cicchini and Jeannine Cicchini. I irrevocably authorize Doctors Perry J. Cicchini and Jeannine Cicchini to file insurance claims and law suits on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Doctors Perry J. Cicchini and Jeannine Cicchini. I irrevocably authorize Doctors Perry J. Cicchini and Jeannine Cicchini to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect and execute it voluntarily.

Patient's Signature: _____ Date: ____ / ____ / ____

Witness: _____



*Dr. Perry J. Cicchini
Dr. Jeannine Cicchini
805 S. Black Horse Pike
Blackwood, NJ 08012*

**AUTHORIZATION RELEASE
MEDICAL RECORDS AND XRAYS**

I, _____ hereby authorize the release of my X-rays and any other medical records or copies of such that may be pertinent to my condition.

Patient's Signature: _____ Date: _____ / _____ / _____

Please fax to:

Dr. Perry J. Cicchini, D.C., P.A.
805 S. Black Horse Pike
Blackwood, NJ 08012

(Fax) 856-228-9323
(Phone) 856-228-8888

BILL CODING EXPLANATION FORM

CODE	EXPLANATION
DN	Spinal manipulation
L	Extraspinal manipulation
V	Vibratory Therapy
T	Traction
R	Rollerbed
W	Waterbed
BIF / BIO	Biofreeze
U	Ultrasound
S	Electrical Stim Machine
K	Carpal Tunnel Machine
ME / ME1	Spinal Manipulation Codes for Medicare patients
B6	Spinal Manipulation Code for Medicaid patients

By signing this form I am confirming that I have received a copy of Doctors Perry J. Cicchini's and Jeannine Cicchini's Billing Code Explanation Form.

Patient's Signature: _____ Date: ____ / ____ / ____

PATIENT MEDICAL QUESTIONNAIRE

Name: _____

Age: _____ Height: _____ Weight: _____ Race: _____

Smoker: ___ Yes ___ No Former Smoker: ___ Yes ___ No

Hypertension: _____ Blood Pressure: _____ Pulse: _____

Please list current medication(s):

_____	_____
_____	_____
_____	_____
_____	_____

Allergies to medication(s) (if applicable):

Would you like to receive our monthly eNewsletter? ___ Yes ___ No