PatientName________________________________Date:__________________

SS #/SIN__________________ DOB_____________ ☐ Male ☐ Female Email: ______________________

Home phone______________________ Cell Phone____________________________

Check appropriate Box: ☐Minor ☐Single ☐Married ☐ Divorced ☐ Widowed ☐ Separated

Address________________________________City__________________State______ Zip________

Employer Name: ____

Spouse or Patient's Guardian name_________________ Spouse's Employer______________________________

Person to contact in case of an emergency____________________________Phone_______________

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Parent or Guardian **Date**

____ ____________________

Was this due to an Accident? ☐ Yes ☐ No if yes, what kind? ☐ Auto ☐ Slip and Fall ☐ Other: _________________

Auto insurance information:

Claim#:____Date of Accident: ____________________

Policy# ____________________Name of insurance Company:______________________________

Claims Adjuster: ____________________________Phone# _____________________________

Do you have an attorney? ☐ Yes ☐ No if yes, what law firm: ______________________________

Who is your case manager or legal assistant: ____

Responsible Party

Name of The Person responsible for this account ____________Relationship to Patient __________________

Address ____Home Phone _________________________

E-Mail ____Cell Phone __________________________

Date of Birth: _____________

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured______________________________ Relationship to patient__________________

Birthdate______________ SS#/SIN_____________ Name of Employer_______________ Work Phone __________

Address of Employer___________________________________ State __________ Zip_______________

Insurance Company_________________________ Group #________________ Union or local # ___________

Ins. Co. Address ______________________ City _______________ State ________ Zip____________

557 Health Blvd., Unit 100
Daytona Beach, FL 32114
Phone: 386.256.3520
Fax: 3862.256.5652

50 Leanni Way, Suite D1
Palm Coast, FL 32137
Phone: 386.283.5997
Fax: 386.283.5652

760 S. Volusia Ave., #100
Orange City, FL 32763
Phone: 386.218.3799
Fax: 386.218.3835

COASTAL HEALTHCARE PARTNERS

Health History

Patient Name: ______________________________ DOB: ____________ Date: __________

Chief Complaint: ______________________________

History of Present illness:

Location: ______________________________
(Where is the pain/problem?)

Quality: ______________________________
(Example: normal vs abnormal color, activity, etc..)

Severity: ______________________________
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: ______________________________
(How long have you had this pain/ problem? When did it start?)

Timing: ______________________________
(Does the pain/problem occur at a specific time?)

Context: ______________________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ______________________________
(What other associated problems have you been having?)

Modifying Factors ______________________________
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES	Bleeding Tendency	NO	YES
Mumps	NO	YES	Bladder Infection	NO	YES	High Blood Pressure	NO	YES	Mitral Valve Prolepses	NO	YES
Chicken Pox	NO	YES	Migraine Headaches	NO	YES	Low Blood Pressure	NO	YES	AIDS & HIV	NO	YES
Whooping Cough	NO	YES	Hemorrhoids	NO	YES	Asthma	NO	YES	Transfusion	NO	YES
Scarlet Fever	NO	YES	Tuberculosis	NO	YES	Hives of Eczema	NO	YES	Stroke	NO	YES
Diphtheria	NO	YES	Diabetes	NO	YES	Hepatitis	NO	YES	Any Other Disease	NO	YES
Small pox	NO	YES	Cancer	NO	YES	Kidney Disease	NO	YES	(Please List):		
Pneumonia	NO	YES	Polio	NO	YES	Ulcer	NO	YES			
Rheumatic Fever	NO	YES	Glaucoma	NO	YES	Thyroid Disease	NO	YES			
Arthritis	NO	YES	Hernia	NO	YES	Infectious Mono	NO	YES			
Venereal Disease	NO	YES	Blood or Plasma	NO	YES	Bronchitis	NO	YES	Date of Last Chest X-Ray__________		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

______________________________ __________ ______________________________
______________________________ __________ ______________________________
______________________________ __________ ______________________________

Medication: (include nonprescription)

____
____
____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O YES O NO if yes what type: ______________________________

Patient Social History:

Marital Status	Single	Married	Separated	Divorced	Widowed
Use of Alcohol	Never	Rarely	Moderate	Daily	
Use of Tobacco	Never	Rarely	Moderate	Daily	
Use of Drugs	Never	Type/Frequency			
Excessive Exposure At home or at work to:	Fumes	Dust	Solvents	Airborne Particles	Noise

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CLINICIAN SIGNATURE: ______________________ **DATE REVIEWED:** ______________________

PATIENT NAME: ______________________ **DOB** __________ **Date:** __________

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father			
Mother			
Sibling's			
Spouse:			
Children:			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/						Respiratory Muscular/Skeletal					
Asthma	1	2	3	4	5	Muscle Aches	1	2	3	4	5
Stuffy Nose	1	2	3	4	5	Fibromyalgia	1	2	3	4	5
Hay Fever	1	2	3	4	5	Arthritis	1	2	3	4	5
Sore throat	1	2	3	4	5	Joint Pain	1	2	3	4	5
Chronic Cough	1	2	3	4	5	Low Back Pain	1	2	3	4	5
Chest Congestion	1	2	3	4	5	Neck Pain	1	2	3	4	5
Frequent Sneezing	1	2	3	4	5	Wrist/Hand Pain	1	2	3	4	5
Itchy/Watery Eyes	1	2	3	4	5	Elbow Pain	1	2	3	4	5
Drainage	1	2	3	4	5	Shoulder Pain	1	2	3	4	5
Earache or Ear Infection	1	2	3	4	5	Hip Pain	1	2	3	4	5
Itching	1	2	3	4	5	Knee Pain	1	2	3	4	5
Hoarseness	1	2	3	4	5	Ankle/Foot Pain	1	2	3	4	5
Shortness of Breath	1	2	3	4	5	Pain b/t shoulder blades	1	2	3	4	5
Wheezing	1	2	3	4	5						

Neurological						General					
Headaches	1	2	3	4	5	Fatigue	1	2	3	4	5
Migraines	1	2	3	4	5	Malaise	1	2	3	4	5
Dizziness	1	2	3	4	5	Weakness, tiredness	1	2	3	4	5
Numbness	1	2	3	4	5	Lightheadedness	1	2	3	4	5
Tingling	1	2	3	4	5	Irritability	1	2	3	4	5
Pins/needles in hands or feet	1	2	3	4	5	Constipation	1	2	3	4	5
						Diarrhea	1	2	3	4	5
						Feeling foggy	1	2	3	4	5
						Forgetfulness	1	2	3	4	5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________ ______________
Signature of the Patient, Parent or Guardian **Date**

Doctor's Review

______________________ ______________
Signature of Doctor Date

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Patient Consent to Use and Disclosure of Protected Health Information

Coastal Healthcare Partners

I hereby give my consent for Coastal Healthcare Partners to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Coastal Healthcare Partners Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice Privacy Practices prior to signing this consent. Coastal Healthcare Partners reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Coastal Healthcare Partners.

With this consent, Coastal Healthcare Partners may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others.

With this consent, Coastal Healthcare Partners may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Coastal Healthcare Partners may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request how Coastal Healthcare Partners uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Coastal Healthcare Partners' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Coastal Healthcare Partners may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

______________________________ ______________________________

Patient's Name Date

____

Print Name of Patient or Legal Guardian

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **COASTAL HEALTHCARE PARTNERS** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of ________________, 20 ____.
(SEAL)

X______________________________________
(Patient signature)

X______________________________________ (SEAL)
(Signature of Guardian if applicable)

X______________________________________
(Please print patient name)

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CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name:______________________________

Patient/Guardian Signature____________________________ Date _______________

Witness Signature ____________________________ Date____________

COASTALHEALTHCARE PARTNERS

OFFICE/PATIENT AGREEMENTS

It has been our experience, caring for thousands of patients over the last 12+ years, that those who agree to and understand the following agreements can benefit the most from their care in our office, helping save you time and money.

Your Consistency of Visits: Our recommendations for your care are customized to your health goals and your body's needs. You need to keep the recommended visits consistent in order to get the best results:

- Meet all your appointments (arrange your activities so you can do this)
- Call us with any emergencies so we can reschedule you

Re-Examinations: In order to monitor your progress, you will receive a re-examination about every three weeks where you will be with one of our health professionals and review your progress since your last examination. New injuries may also require an exam.

Adjusting Area: After completing your daily progress, you will go back to the treatment area unless you are scheduled for a re-examination.

Special Visits: These visits are anything other than your regular chiropractic adjustments and/or physical rehabilitation. We do our best to keep your waiting in our office to a minimum; however, we need your help to continue this goal: Please be punctual for these visits.
If you desire to schedule a special non-emergency visit such as a nutritional consultation or other special visit, we ask you give us at least one visit notice in advance.

New Symptoms or Flare Up: If you experienced any new symptoms or change of health you need to let us know immediately before your next visit.

Symptom Changes: As we balance your body, just like a new exercise program, you may experience some soreness, this may happen anytime during your care in our office. If this occurs simply inform us when you come in and we can discuss this with you.

Payment of Bills: We will expect you to honor the financial agreement you make with our office; If you find that you cannot fulfill the agreement you have made with us, you need to go to the front desk, and tell one of our staff so that we can discuss with you new arrangements to be made. Insurance companies will be billed for your services rendered if you have such insurance coverage. If you receive any checks from your insurance company, it is your responsibility to bring them into our office within 3 days of receiving them along with the "Explanation of Benefits" attached to the insurance check. If you fail to bring in the insurance checks and/or the "Explanation of Benefits", we reserve the right to bill you directly for those services. Methods of payment are Visa, Master Card, Cash, Check and Care Credit.

Upsets: If you ever have any questions or concerns of any fashion concerning your care in our office, please talk to a staff member immediately so we can answer your questions and help you.

I fully understand and accept these policies.

_________________________________ ____/____/____

Patient Signature Date

____

Staff Member Signature

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________ Date of Birth: __________

Organization Providing Information:
Name of Person or organization releasing information

Organization Requesting Information:
Name of Person or organization releasing information

Coastal Healthcare Partners - Palm Coast
50 Leanni Way, Suite D1, Palm Coast, FL 32137
Phone: 386-283-5997 Fax: 386-283-5652

Coastal Healthcare Partners – Daytona
557 Health Blvd. Unit 100, Daytona Beach, FL 32114
Phone: 386-256-3520 Fax: 386-256-3516

Coastal Healthcare Partners – Orange City
760 S. Volusia Ave., #100, Orange City, FL 32763
Phone: 386-218-3799 Fax: 386-218-3835

Specific records to be released: ☐ X-Rays ☐ History ☐ Diagnosis ☐ Treatment ☐ Reports ☐ Medications prescribed

☐ Records concerning accident on ____________ (date)

☐ All care given at your facility covering the period from ________________ to ________________

- I understand that I may refuse to sign this authorization, and that it is strictly voluntary.
- I understand that I have the right to withdraw my authorization at any time, except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Clinic's Privacy Officer.
- I understand that protected health information released pursuant to this authorization may include records generated by another healthcare provider or facility.
- I understand that I have the right to inspect or copy the protected health information to be used or disclosed, as permitted under federal law.
- I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by confidentiality laws.
- I understand that I have a right to receive a copy of this authorization.
- I understand that I do not have to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment.
- I understand that certain records may be protected by federal or state law, and I am requesting that any and all such protected records be released under this authorization (e.g., treatment if alcohol and drug abuse, mental health services, information about sexually transmitted disease and HIV/AIDS-related treatment).
- I understand that there may be fees associated with some medical records requests.

I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. This authorization is effective for one year.

Patient Signature: ______________________ Date: __________

If signed by someone other than the patient please indicate the relationship below:

☐ Parent or Guardian of Minor Patient ☐ Guardian or Conservator of an incompetent patient

☐ Beneficiary of personal representative of deceased patient

☐ Other (Specify) ______________________________

Identification Verified By: ______________________________

Photo Identification: State/Other: ______________________________