Dr. Beth Kozak
5540 PGA Boulevard
Suite 100
Palm Beach Gardens, Florida 33418
www.namastechiropractic.com
office: 561-619-7319
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New Patient Information Form

Welcome!

Please provide us with the following information:

Patient First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code _____

Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Out-of-State Address (*if applicable*): _____

City: _____ State: _____ Zip Code: _____

Number of Children & Ages: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Date of Birth: _____ Age: _____

Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not-Employed

Employer: (*if applicable*) _____ Occupation: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Policy #: _____ Group #: _____

*Please complete **only** if Patient **is not** the insured:*

Insured's Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female

Secondary Insurance Company Name: _____

Policy #: _____ Group #:_____

*Please complete **only** if Patient **is not** the insured:*

Insured's Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female

AUTOMOBILE ACCIDENT / WORKERS COMPENSATON

Insurance Company Name: _____ Claim#: _____

Date of incident: _____ Phone#: _____ ext: _____

Attorney's Name: _____ Phone#: _____

COMPLAINTS

Primary Complaints/ Reasons for appointment	**Pain rating on scale of 1 – 10**	**Date condition started or for how long?**	**Have you experienced this condition in the past?**	
1.			☐ **yes**	☐ **no**
2.			☐ **yes**	☐ **no**
3.			☐ **yes**	☐ **no**

If you have experienced current complaint(s) prior, what Doctors have you consulted or treatment options have you tried?

_____

_____

_____

Please list any medications and/or supplements you are currently using: ☐ **none**

1.	2.	3.	4.
5.	6.	7.	8.

Are you allergic to any medications? ☐ **Yes** ☐ **no**

If yes, please list: _____

List any previous surgeries and dates _____

_____

_____

Do you smoke? ☐ **yes** ☐ **no**

Do you drink soda? ☐ **yes** ☐ **no**

Do you exercise? ☐ **yes** ☐ **no**

What Chiropractic Doctors have you consulted in the past?

Name:_____ Date:_____ Reason:_____

Date of last spinal x-ray? _____ How long were you under their care? _____

Female Patients…is there a possibility of a current pregnancy? ☐ **yes** ☐ **no**

Please circle any of the the following conditions you may have experienced in the past or are experiencing now:

Headaches	Arthritis	Insomnia	High Blood Pressure	Digestive Issues
Migraines	Joint Pain	Stroke	Blood Vessel Disease	Ulcers
Neck Pain	Numbness	Vision Changes	Menstrual Cramps	Constipation
Shoulder Pain □ L □ R	Joint Swelling	Nose Bleeds	Irregular Periods	Urinary Problems
Arm/Hand Pain	Scoliosis	Ringing in the ears	Allergies	Kidney Problems
Mid-back Pain	Flat Feet	Earaches	Asthma	Gallbladder Problems
Low-back Pain	Dizziness	Hearing Loss	Cancer	Tuberculosis
Hip Pain □ L □ R	Nausea	Cough	Osteoporosis	Gout
Leg Pain □ L □ R	Weakness/Fatigue	Chest Pain	Diabetes	Depression
Disc Problems	Nervousness	Heart Problems	Hypoglycemia	Other

Patients often visit chiropractors to reach one of two objectives concerning their healthcare. Some patients seek symptomatic relief of their pain or discomfort, also known as "***relief care***". Others are interested in discovering the cause of their problem and set goals towards correcting and relieving their problem, known as "***corrective care***".

RELIEF CARE	**CORRECTIVE CARE**
Relief care gets rid if symptoms or pain, but not the cause of it. The initial problem is likely to return.	Corrective care differs from relief care in that the goal is to get rid of symptoms AND correct the cause of the problem

Please check your desired type of care: □ Relief Care □ Corrective Care □ Not Certain

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Treatment Consent Form

Consent for Treatment

I hereby give my consent for Namaste Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) such as:

- release of information to family physicians and employer
- release of information to insurance companies
- taking photographs and x-rays to be used for treatment purposes
- perform other diagnostic and therapeutic procedures for treatment purposes

I authorize my insurance benefits to be paid directly to:

Namaste Chiropractic
5540 PGA Boulevard Suite 100
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I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, fees for professional services rendered me will be IMMEDIATELY due and payable. I agree that I will be responsible for all attorney a legal fees if legal action becomes necessary to collect unpaid debts.

Payment Policies

PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.

At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Consent to Treatment of Minor Child (*if applicable*)

I hereby authorize Namaste Chiropractic to administer treatment as they so deem necessary to my son/daughter/other,

_____ .
(Print Patient Name)

_____ _____
(Parent or Guardian Signature) (Date)

namaste CHIROPRACTIC

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TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.
Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's God-given ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's God-given wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I_____ have read and fully understand the above statement.
(*print name*)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
(*patient signature*) (*date*)

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NOTICE OF PRIVACY FORM

Receipt of Notice of Privacy Practices Written Acknowledgment Form

Namaste Chiropractic

I, _____ have read a copy of Namaste Chiropractic's Notice
(*print patient name*)

of Patient Privacy Practices.

_____ _____
(Signature of Patient or Parent or Legal Guardian) (*Date*)