

DR SCOTT JURICA, DC, PAK, ACN
406 W 22nd St, NY, NY 10011 (9th Ave and 22nd St)
212-533-3631 * info@drscottjurica.com * www.drscottjurica.com

PLEASE PRINT

DATE: _____

PERSONAL INFORMATION

NAME _____ EMAIL _____ Signup for Newsletter: Y/N
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE (Work) _____ (Cell) _____ SSN. _____ DOB _____
MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF CHILDREN _____
OCCUPATION _____ EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____
EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

EMERGENCY NOTIFICATION

NAME _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
REFERRED BY _____

CONSENT TO TREATMENT

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

Date _____ Patient's Signature _____

24 HOUR CANCELLATION POLICY

In the event an appointment is missed without notifying the office within 24 hours, the patient will be charged for the appointment

Date _____ Patient Signature _____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Dr. Scott Jurica to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date _____ Patient's Signature _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT _____

HOW DID IT HAPPEN? _____

TODAYS CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

TYPE OF TREATMENT _____ RESULTS _____

Habits

- Alcohol: Type _____ Continuity disturbances _____ Exercise routine: _____
- Amount _____ Early morning awakenings _____
- Diet: Salt intake _____ Daytime drowsiness _____
- Fat intake _____ Other _____
- Other _____ Smoking: Packs daily _____ Caffeine: Coffee, cups daily _____
- Sleep: Difficulty falling asleep _____ How long _____ Other _____
- Interested in stopping? _____

MEDICATIONS: _____

DRUG ALLERGIES: _____

Medical History

- RINGING IN EAR _____ GALL BLADDER TROUBLE _____ TREMOR/HANDS SHAKING _____ MEASLES RUBELLA RHEUMATIC FEVER
 - EAR INFECTIONS - FREQUENT _____ JAUNDICE/HEPATITIS _____ MUSCLE WEAKNESS _____ SCARLET FEVER TUBERCULOSIS HERPES
 - DIZZINESS/FAINTING _____ CHANGE IN BOWEL HABITS _____ NUMBNESS/TINGLING SENSATIONS _____ OTHER _____
 - FAILING VISION _____ DIARRHEA CONSTIPATION _____ HEADACHES - FREQUENT _____ OTHER _____
 - EYE INFECTIONS _____ DIVERTICULOSIS CROHN'S/COLITIS _____ ARTHRITIS/RHEUMATISM _____
 - NOSE BLEEDS _____ BLOODY OR TARRY STOOLS _____ OSTEOPOROSIS _____
 - SINUS TROUBLE _____ HEMORRHOIDS _____ BACK PAIN - RECURRENT _____
 - SORE THROATS - FREQUENT _____ HERNIA _____ BONE FRACTURE/JOINT INJURY _____
 - HAYFEVER/ALLERGIES _____ URINE INFECTIONS - FREQUENT _____ GOUT _____
 - PNEUMONIA _____ BLOOD IN URINE _____ FOOT PAIN COLD NUMB FEET _____
 - BRONCHITIS/CHRONIC COUGH _____ URINATION OVERNIGHT > THAN TWICE _____ RASHES HIVES _____
 - ASTHMA/WHEEZING _____ PAINFUL LOSS OF CONTROL _____ PSORIASIS ECZEMA _____
 - CHEST PAIN _____ DECREASE IN FORCE/FLOW _____ NERVOUSNESS DEPRESSION _____
 - HIGH BLOOD PRESSURE _____ KIDNEY STONES _____ MEMORY LOSS _____
 - HEART MURMUR _____ VENEREAL DISEASE _____ MOODINESS - EXCESSIVE _____
 - SWOLLEN ANKLES _____ URETHRAL DISCHARGE _____ PHOBIAS _____
 - LEG PAIN - WALKING _____ CHRONIC FATIGUE _____ MENTAL ILLNESS _____
 - VARICOSE VEINS/PHLEBITIS _____ WEIGHT LOSS - RECENT _____ LACTOSE INTOLERANCE _____
 - LOSS OF APPETITE _____ ANEMIA BRUISE EASILY _____ PROSTATE DISEASE _____
 - DIFFICULTY SWALLOWING _____ CANCER _____ SEXUAL/MENSTRUAL DYSFUNCTION _____
 - INDIGESTION OR HEARTBURN _____ DIABETES _____ FREQUENT INFECTIONS _____
 - PERSISTENT NAUSEA/VOMITING _____ THYROID DISEASE _____ DIPHTHERIA _____
 - PEPTIC ULCERS _____ CONVULSIONS/SEIZURES _____ TETANUS _____
 - ABDOMINAL PAIN - CHRONIC _____ STROKE _____ CHICKEN POX POLIO MUMPS
- Females - Please Complete**
- PREGNANT? YES NO
- PLANNING PREGNANCY? YES NO
- Menstrual Flow: _____
- Regular Irregular Pain/Cramps
- _____ Days of Flow _____ Length of Cycle
- Date-1st day of last period _____
- Pain/Bleeding during or after sex
- Number of:** _____
- _____ Pregnancies _____ Abortions
- _____ Miscarriages _____ Live Births
- Birth Control Method _____
- B.C. Pill (Name) _____
- Flushing/Menopause
- Date of Last PAP Test _____
- Normal Abnormal
- Date of Last Mammogram _____
- Normal Abnormal

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS				BLOOD DISEASE	
				GLAUCOMA	
				EPILEPSY	
SPOUSE				RHEUMATOID	
				ARTHRITIS	

CHILDREN	_____	_____	_____	TUBERCULOSIS	_____
	_____	_____	_____	GOUT	_____
	_____	_____	_____	HIGH BLOOD	_____
				PRESSURE	_____
				HEART DISEASE	_____
				BACK	_____
				PROBLEMS	_____

Insurance Information:

Do you have health insurance and/or Medicare? Yes No

Is your condition due to an auto accident or job related injury? Yes No

Insurance Company _____ Policy # _____

Policy Holder _____

Patient relationship to insured: Self ___ Spouse ___ Child ___ Other ___

Please read the following carefully:

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will answer reasonable administrative requests from your insurance carrier without additional fee. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of whether or not it's paid by the insurance carrier.

Patient's Signature _____ Date _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Scott Jurica to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Dr. Scott Jurica describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Scott Jurica reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Scott Jurica. The current version of the Notice of Privacy Practices is available at all times by visiting us on the web at www.drscottjurica.com

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

With this consent, Dr. Scott Jurica 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, Dr. Scott Jurica 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 that Dr. Scott Jurica restrict how it uses or discloses my PHI to carry out TPO. 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 allow Dr. Scott Jurica to use and disclose 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, Dr. Scott Jurica may decline to provide treatment.

Signature: _____

Signature of Patient or Legal Guardian Date Relationship to Patient

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."*

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advise is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).

I have read and understand the above:

Signature: _____ Date: _____

NOTICE OF UNDERSTANDING AND AGREEMENT:

I hereby, attest to the following:

1. I fully understand that the Nutrition Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures.
2. The services performed by the Nutrition Consultant are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that as a Nutrition Consultant the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, any act which will constitute the practice of medicine in this state, for which a license is required.

Signed _____ Date _____

Print name _____