FLORIDA SPINE & DISC

Date: ____/____/____

PATIENT REGISTRATION

UNDER THE "FED. PRIVACY ACT" – ID IS REQUIRED TO: REGISTER AS A PATIENT, PROVE INSURANCE, OR LEGALLY CHANGE NAME

Patient Name: _____
(Last) (First) (Initial) (Maiden)

Guarantor Name: _____
(If not patient) (Last) (First) (Initial) (Maiden)

LOCAL Patient Address : _____

_____ ( ) _____ - _____
(City) (State) (Zip) (Phone)

OUT OF STATE Address : _____

(Guarantor's if Different) _____ ( ) _____ - _____
(City) (State) (Zip) (Phone)

Patient Date of Birth: ____/____/____ Sex: Male ❑ Female ❑ Patient's SS#: _____/_____/_____

Driver's Lic# ID #:_____ Issued from State of:_____

Patient/Guarantor's Marital Status ❑ Married ❑ Divorced ❑ Single ❑ Widowed

(Spouse Name: _____) Work# ( ) _____ - _____

In Case of Emergency - (Someone other than at same address or phone number) – Notify the following

Name: _____
Relationship

Address: _____

_____ ( ) _____ - _____
(City) (State) (Zip) (Phone)

What is your chief complaint? _____

When and how did symptoms start? _____

Is the condition progressively getting worse? Y / N Do you have an MRI? Y / N If yes, when? _____

Does the pain radiate or travel? Y / N If yes, where? _____

Do you have numbness/tingling? Y / N If yes, where? _____

Rate your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine: _____

Does anything aggrevate it? Y / N If yes, what? _____

Does anything make the pain better? Y / N If yes, what? _____

Other physicians who have treated this complaint: _____

IMPORTANT!! PLEASE READ CAREFULLY

Payment Agreement:
I agree to be responsible to pay in full for services rendered ***OR*** to assist with any action required by me for my insurance to pay. Filing my insurance is a service provided by the office(s) of Jason B. Kaster, D.C. , Amanda Ferguson, D.C. or Tanya Horsten, D.C. on my behalf. I remain responsible to call my insurance (if I have not heard from them) regarding payment within 30 (thirty) days after my appointment. **I agree to pay my co-pay or coinsurance portion promptly and any amount my insurance (including medicare) indicates as "my responsibility. As a medicare patient, I understand this office has not verified my supplemental benefits and I agree to be responsible to file a copy of my medicare summary along with any "duplicate non-assigned" claims provided by** _____(Insurance is to reimburse me for all non-assigned claims)

_____
Guarantor/Patient Signature Date

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9955 Tamiami Trail N, Suite 1 • Naples, FL 34108

CONSTITUTIONAL:	NO	YES
Good General Health Lately?		
Recent weight: Gain? Loss?		
Fever?		
Fatigue?		
Frequent Headaches?		
Other:_____		

EYES:		
Eye disease? or injury?		
Wear glasses? Contacts?		
Blurred vision? Double vision?		
Glaucoma?		
Other:_____		

EARS/NOSE/MOUTH/THROAT		
Hearing loss? Ringing? Pain?		
Chronic sinus problem/s?		
Frequent: nose bleed? Bleeding gums?		
Mouth sores?		
Frequent sore throat? Recent voice change?		
Swollen glands in neck?		
Other:_____		

CARDIOVASCULAR		
Heart problem?		
Chest pain?		
Irregular heart beat?		
Shortness of breath? Walking? Lying flat?		
Swelling of: Feet? Ankles? Hands?		
Other:_____		

MUSCULOSKELETAL		
Joint pain in		
Joint stiffness? Swelling?		
Weakness of: Muscle? Joints?		
Muscle: Pain? Cramps?		
Frequent back pain?		
Difficulty walking?		
Other:_____		

GENIROURINARY		
Urination: Frequent?		
Cuts? Burning? Painful?		
Incontinence? Dribbling?		
Kidney Stones?		

SKIN AND BREAST	NO	YES
Unusual Rash? Itch?		
Change in: Skin color? Hair? Nails?		
Frequent breast pain?		
Breast Lumps? Discharge?		
Other:_____		

NEUROLOGICAL		
Headaches? Frequent? Recurrent?		
Light headed? Dizzy? Fainting?		
Convultions? Seizures?		
Other:_____		

PSYCHIATRIC		
Frequent: Memory Loss? Confusion?		
Frequent: Nervousness? Depression?		
Other:_____		

ENDOCRINE		
Glandular? Hormone problems?		
Throid disease?		
Diabetic?		
Excessive: Thirst? Urination?		
Heat or cold intolerance?		
Other:_____		

RESPIRATORY		
Cough: Chronic? Frequent?		
Spitting up blood?		
Shortness of breath?		
Asthma? Wheezing?		
Other:_____		

GASTROENTESTINAL		
Loss of appetite?		
Change in bowel moements?		
Frequent: Nausea? Vomitting?		
Rectal bleeding? Blood in stool?		
Black tarry stool?		
Peptic Ulcer disease?		
Other:_____		

HEMATOLOGIC/LYMPHATIC		
Slow to heal		
Tendency to: Bleed? Or, bruise easily?		
Anemia?		
Phlebitis?		
History of blood transfusions?		
Enlarged glands?		

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SURGERY HISTORY

	NO	YES	
Appendix Removed?			When?_____/_____/_____
Biopsy of?_____			When?_____/_____/_____
Gall Bladder Removed?			When?_____/_____/_____ Why? _____
Heart Surgery?			When?_____/_____/_____ Kind? _____
Hysterectomy?			When?_____/_____/_____ Why? _____
Ovaries Removed?			When?_____/_____/_____ Why? _____

Others: _____

_____

Medications/Supplements: _____

_____

FAMILY HISTORY

Father	Living	____	Age: ____	Problems:_____
	Deceased	____	Age: ____	Cause of Death: _____
Mother	Living	____	Age: ____	Problems:_____
	Deceased	____	Age: ____	Cause of Death: _____
Siblings	Living	____	Age: ____	Problems:_____
			Age: ____	Problems:_____
			Age: ____	Problems:_____
	Deceased	____	Age: ____	Cause of Death: _____
	Deceased	____	Age: ____	Cause of Death: _____
	Deceased	____	Age: ____	Cause of Death: _____
Children	Living	____	Age: ____	Problems:_____
			Age: ____	Problems:_____
			Age: ____	Problems:_____
	Deceased	____	Age: ____	Cause of Death: _____

Any one in your family has/had: Colon Cancer? No:_____ Yes:_____ Breast or Ovarian Cancer? No:_____ Yes:_____

Who? _____

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Naples Chiropractic Associates • 9955 Tamiami Trail North, Suite 1 • Naples, FL 34108
Kaster Inc. (Jason B. Kaster, D.C.) • 1791 Boy Scout Drive, Suite 6 • Fort Myers, FL 33907

Patient Name (print):_____ Date of Birth:_____

FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office and I accept any responsibility for charges, which may not be approved. The insurance company will review any/all documentation submitted by **Kaster Inc. (dba Jason B. Kaster, D.C.), and/or Amanda Ferguson, D.C. and Tanya Horsten, D.C. (hereinafter referred to as "Naples Chiropractic Associates")** for review for medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my care is not approved by the insurance company. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company. This office may seek payment from you for any services your health insurance plan determines not to be medically necessary. I have read and understand my obligations for payment in the absence of insurance coverage.

Patient's initials:_____

ASSIGNMENTS OF BENEFITS & DIRECTION TO PAY

I hereby authorize my insurance company from whom I may be entitled to personal injury and/or medical payments benefits to make said payments otherwise payable to me for services rendered by **Kaster Inc. (dba Jason B. Kaster, D.C.) and Naples Chiropractic Associates**, but not to exceed to charges of those services, payable to and mailed directly to:

Kaster Inc., 1791 Boy Scout Drive, Suite 6, Fort Myers, FL 33907
- or -
Naples Chiropractic Associates, 9955 Tamiami Trail North, Suite 1, Naples, FL 34108

Furthermore, I hereby irrevocable assign to **Kaster Inc. (dba Jason B. Kaster, D.C.), and Naples Chiropractic Associates** the rights and benefits, including the right to file and prosecute a lawsuit for the collection of personal injury and/or medical payments benefits, under and policy of insurance, including those policies of insurance from which I may be entitled to personal injury and/or medical payments benefits, indemnity agreement, or any other collateral source as defined in Florida statues for any service and or charges provided by **Kaster Inc. (dba Jason B. Kaster, D.C.) and Naples Chiropractic Associates**. I understand that in ex- change for this assignment of said rights and benefits. I will receive medical treatment from **Kaster Inc. (dba Jason B. Kaster, D.C.) and Naples Chiropractic Associates**.

Patient's initials:_____

INSURANCE ASSIGNMENT DISCLAIMER

Our office is pleased to accept your insurance assignment. However, it must be understood that the contract with your insurance company is between you and your insurance company. We will make every effort to file your insurance claim form and assist you in obtaining your rightful benefits. Please understand that you are fully responsible for any fees incurred by you and not reimbursable or collectable from your insurance carrier.

Naturally, you are responsible for any deductible or co-insurance payments you have contracted for with your insurance company. Most insurance companies cover care provided within this office. However, some companies have limits on their coverage. We will try to confirm your coverage and determine which services will be covered, what your deductible is, and what you are responsible for. Once we obtain the information we will discuss it with you. Payment of co-insurance / co-pay will be expected the day services are rendered. You are welcome at any time to review your current charges and receive copies of your bills and records.

Patient's initials:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined that opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient's initials:_____

Patient signature: _____ Witness: _____