Longinotti Chiropractic Center New Patient Questionnaire

Patient Information

Patient I.D. _____

Please Print

Name_____ Date_____ SS#_____

Address_____City_____ State_____ Zip_____

❑Male ❑Female ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated

Birthdate_____ Home Phone_____ Cell_____

Work Phone_____ E-mail Address_____

Employer_____ Occupation_____

Business Address_____City_____ State_____ Zip_____

Spouse or Parent's Name_____ Birthdate_____ Phone _____

Emergency Contact_____ Phone _____ Relation_____

Whom may we thank for referring you to us? _____

Did you see our Newspaper Flyer?_____ Yellow Page Ad? _____ Other?_____

Name of local primary Physician_____ May we contact them?____

Insurance Information – *If Insured, Please provide copy of insurance card*

SYMPTOMS

Main Complaint_____ How Bad?_____ How Often?_____

When did it start?_____Getting Worse?_____Getting Better?_____

What activity bothers it the most? _____

When is it at its best?_____ When is it at its worst?_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ Positive Experience?_____

Other type of physician or therapist?_____ Positive Experience?_____

Secondary Complaint_____

Health History - *Please circle all that apply*

AIDS/ HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M. S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V. D.	Whooping Cough	
Chronic Fatigue	High Blood Pressure		Fibromyalgia	Other			

Women - How many children?_____Pregnant?_____Date of last Menstrual Cycle_____

Nursing?_____Taking Birth Control Pills?_____

Previous Surgeries and Dates? _____

_____

List ALL Medications you are currently taking _____

_____

What kind of exercise do you do? _____

What supplements do you take?_____

How much do you smoke per day?_____ Drink per week? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature_____ Date_____

Longinotti Chiropractic Center, Ltd.

Specializing in Back and Neck Pain

Dr. John Longinotti-Director

Certified, National Board of Chiropractic Examiners

American Chiropractic Association

Parker Chiropractic Research Foundation

Illinois Prairie State Chiropractic Association

On Staff

Certified Massage Therapists

Acupuncturist

Effective Relief & Rehab From

Lower Back Pain

Neck Pain

Arm & Leg Pain

Headaches

Stress Tension

Auto Injuries

Work Injuries

For Your Convenience

Insurance Filed for You

Payment Plans

Medicare Assignment

Handicap Equipment

Emergency Phone Number

Evening and Weekend Hours

CONSENT TO EXAMINE AND/OR TREAT

Being of sound mind and of my own free will, I have entered the office of John R. Longinotti, D.C., for the expressed purpose of consultation, examination and possible treatment of injuries and/or illnesses for which I believe Dr. Longinotti may be able to treat. I understand certain risks are associated with any form of health care examination and/or treatment and am willing to assume such risks, releasing Dr. Longinotti and/or his staff of any consequences thereof.

RELEASE OF INFORMATION

I authorize Dr. John Longinotti and his staff to release any information pertinent to my case to any insurance company, adjustor, attorney and/or other health care provider involved with my treatment by Dr. Longinotti. I hereby release Dr. Longinotti, the Longinotti Chiropractic Center, Ltd., and its staff of any consequences thereof.

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check, made out and mailed directly to John R. Longinotti, D.C., and/or the Longinotti Chiropractic Center, Ltd., the professional and chiropractic expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by Dr. Longinotti and/or his staff.

In addition I agree to be financially responsible for all charges incurred at this clinic per established fee policy, including any and all insurance deductibles, co-pays, co-insurance, and services not covered by my insurance company. I also agree to be responsible for any reasonable collection and/or attorney fees.

The notice of Privacy Practices is available at the front desk. If you would like a copy, please ask at the front desk.

Dated this _____ day of _____, 2023, at Oak Park, IL.

_____ _____

Patient/Guardian **Witness**

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