CONFIDENTIAL PATIENT CASE HISTORY

Please answer all questions completely

Dear Patient: This information is considered confidential. Your answers will help us determine if Chiropractic Care can help you. If I do not sincerely believe your condition will respond satisfactorily, I will not accept your case. Please be as neat and accurate as possible while completing this form. Thank you.

NAME _____ ADDRESS _____

CITY _____ STATE____ ZIP_____ DOB ___/___/_____ AGE___

HOME PHONE (_____)-_____-_____ WORK (_____)-_____-_____x_____ CELL (_____)-_____-_____

EMAIL _____ _____ SS# _____-_____-_____ MARITAL STATUS _____

SPOUSE'S NAME_____ # CHILDREN _____ AGES _____

OCCUPATION_____ REFERRED BY _____

WHAT IS YOUR CHIEF COMPLAINT? _____

WHAT DOES THE COMPLAINT INTERFERE WITH? _____

WHAT ARE YOUR GOALS WITH TREATMENT?_____

HOW LONG HAVE YOU HAD THIS CONDITION? _____ SIMILAR CONDITIONS IN THE PAST?_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

IS CONDITION GETTING WORSE? YES____ NO____ CONSTANT_____ COMES & GOES?_____

HAVE YOU LOST DAYS FROM WORK? YES____ NO____ DATES_____

HAVE YOU RECEIVED PREVIOUS CHIROPRACTIC CARE?____ FROM WHOM?_____

OTHER DOCTORS WHO HAVE TREATED THIS CONDITION_____

LISTS SURGICAL OPERATIONS AND YEARS_____

_____

DRUGS/VITAMINS YOU NOW TAKE AND CONDITION BEING TREATED:_____

_____

ANY OTHER JOB RELATED INJURIES or ACCIDENTS?____ DESCRIBE_____

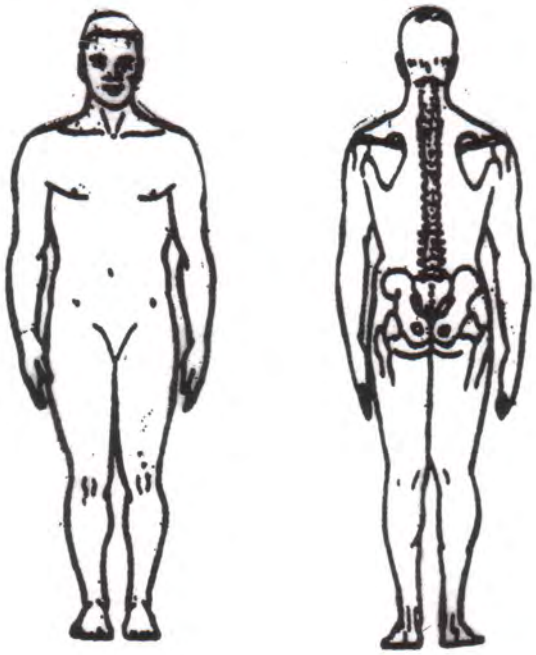
INSURANCE COMPANY NAMES & POLICY #s_____

I understand and agree that health insurance and accident policies are an arrangement between my insurance company and me. I understand that any amount authorized to be paid directly to Dr. Santoro will be credited to my account upon receipt. However, 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 also understand that if I suspend or terminate my treatment, any fees for professional services renderd will be immediately due and payable.

I will be paying today by cash _____ check _____ credit card_____ MC___ VISA___ Am Exp____ Disc____
Card #_____ Exp date_____

PATIENT SIGNATURE_____ GUARDIAN_____ DATE ___/___/____

PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAMS BELOW. ALSO, DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN. FOR EXAMPLE, NOTE WHETHER THE PAIN IS DULL, SHARP, WHEN STANDING, SITTING, ETC.



DIABETES_____HEART DISEASE_____
CANCER_____HEADACHES_____
STOMACH_____BLOOD PRESS_____
NECK PAIN_____ALLERGIES_____
OTHER_____

DATE OF LAST PHYSICAL_____
FINDINGS OF THE EXAMINATION_____
_____
_____

ASSIGNMENT OF BENEFITS

IF YOUR CASE IS THE TYPE THAT ALLOWS FOR AUTHORIZATION OF ASSIGNMENT OF BENEFITS, AND THIS PRIVILEGE IS EXTENDED TO YOU, PLEASE SIGN THE ASSIGNMENT OF BENEFITS FORM BELOW.

DEAR INSURANCE ADJUSTER,

BELOW YOU WILL FIND A SIGNED AUTHORIZATION FROM YOUR INSURED FOR DIRECT PAYMENT OF HIS/HER MEDICAL BILLS. PAYMENTS SHOULD BE MADE TO DR. ALFRED J. SANTORO

THIS REQUEST BY YOUR INSURED IS NOT ANY TYPE OF ASSIGNMENT TO BE BOUND BY FLORIDA STATUTE 627.736(5). THIS REQUEST BY YOUR INSURED IS MERELY FOR CONVENIENCE AND TIMELINESS IN PAYMENT FOR MEDICAL SERVICES PROVIDED.

ALFRED J. SANTORO, BA, BS, CCSP, DC DATE

I HEREBY AUTHORIZE DIRECT PAYMENT TO DR. ALFRED J. SANTORO FOR PROFESSIONAL SERVICES I HAVE RECEIVED.

PATIENT SIGNATURE DATE

PLEASE NOTE:ASSIGNMENT OF BENEFITS DOES NOT MEAN THAT YOU HAVE NO RESPONSIBILITY OF PAYMENT. IN MOST CASES, YOU WILL STILL HAVE A COPAYMENT OR DEDUCTIBLE TO MEET. ALSO, IF YOUR INSURANCE DOES NOT PAY YOUR BILLS OR DOES NOT PAY FOR A SPECIFIC PROCEDURE, YOU ARE RESPONSIBLE FOR SERVICES YOU RECEIVE.

PATIENT SIGNATURE DATE