



New Haven Chiropractic Group

Date _____

IF THE INJURY IS DUE TO AN AUTOMOBILE ACCIDENT; SLIP & FALL OR WORK RELATION,
PLEASE NOTIFY THE FRONT DESK RECEPTIONIST BEFORE FILLING OUT PAPERWORK.

PLEASE CHECK OFF APPROPRIATE INSURANCE INFORMATION AND GIVE YOUR INSURANCE
CARD(S) TO THE FRONT DESK RECEPTIONIST.

THANK YOU.

Anthem Blue Cross/Shield _____ Blue Cross/Shield Teamsters _____

Blue Care Family _____ Landmark/PHS _____

Connecticare _____ Aetna U.S. Healthcare _____

Yale Preferred _____ Cash _____ Other _____

Name _____ Social Security _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

E-mail Address _____

Birth Date ____/____/____ Age _____ Male _____ Female _____ Marital Status _____

Occupation _____ Employed By _____

Address _____ City _____ State _____ Zip Code _____

Who referred you to our office? _____

Have you had Chiropractic Care before? Yes or No

Approximate Date of Last Physical ____/____/____

Are you presently under any other physician's care? Yes or No

(for women) Is there any chance that you are pregnant? Yes or No

PAIN DRAWING

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Pain	=++++
Dull and Achy	=VVVV
Pins and Needles	=OOOO
Numbness	=///

LOCATION AND TYPE OF PAIN
(WHERE DOES IT HURT?)



**NEW
HAVEN
CHIROPRACTIC
GROUP**

DR. JAMES CIANCIOLO

DR. SARAH LEVIN

1. I hereby authorize New Haven Chiropractic Group to receive any information which may have been acquired by examination or other means of my physical condition, and hereby release them of any consequences thereof.

2. I acknowledge that I have received and or read the privacy statement acknowledgement of the New Haven Chiropractic Group.

3. I hereby authorize release of information necessary to file a claim with my insurance company.

5. Patient is responsible for any outstanding balances due to the New Haven Chiropractic Group.

6. I assign benefits otherwise payable to me to the New Haven Chiropractic Group.

Date: ____/____/____

PATIENT PRINT

PATIENT SIGNATURE



DR. JAMES CIANCIOLO

DR. SARAH LEVIN

At New Haven Chiropractic Group maintaining our patients' trust and confidence is very important to us. That is why we have made it our priority to keep the information you provide us safe and confidential. Our employees are educated on the importance of maintaining the confidentiality of your health information. The Practice's Privacy Notice has been provided to me prior to my signing this form. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Practice explained to me that the Privacy Notice is available to me now, or in the future at my request.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. I understand that, and consent to, the following appointment reminders that may be used by the Practice: a postcard mailed to me at the address provided by me; telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. I understand that I have a right to request an accounting of the disclosure of my PHI other than for treatment, payment and/or health care operations. I understand I may restrict access or disclosure of my PHI. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to be requested restriction, then the restriction is binding on the Practice. I understand the Practice may share my PHI with the Connecticut Chiropractic Association in the event advocacy is needed for insurance claims or utilization disputes. I acknowledge that I have received the Privacy Statement of the New Haven Chiropractic Group.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Relationship

Date: ____/____/____

Witness



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Informed Consent to Chiropractic Treatment

While rare, some patients may experience short term aggravation of symptoms, rib fractures, muscle and ligament strains/sprains, and dizziness as a result of manual therapy techniques. There are reported cases of stroke associate with many common neck movements including adjustment of the upper cervical spine. The apparent association is noted infrequently, however, you are being warned of this possible association because stroke can cause serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is rare, however, possible. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Name _____ **Date:** ____/____/____

Witness Name _____ **Date:** ____/____/____