

Zanetti Chiropractic, Inc
Family Wellness Center
Dr. Dina Zanetti DeBolt
4817 NE 2nd Loop
Ocala, FL 34471
(352) 624-2337 Fax (352) 624-3501

Referred By: _____

Dear New Patient:

Welcome to our office. In order for us to provide you with the best chiropractic care, please take the time to fill out the following information completely:

Patient information:

First Name Middle Last Name

Mailing Address

City State Zip Code

() - () -
Home Phone Work Phone

- - / /
Social Security No. Birth Date

Marital Status: Single Married Divorced Widowed

Occupation: _____

Employer's Name and Address:

E-Mail Address: _____

Method of Payment for Today's Visit
 Check Cash Credit Card

Insurance Information:

Company Name: _____

Mailing Address: _____

Phone #: _____

Insured's ID#: _____

How much is your deductible? \$ _____

Have you met your deductible this year? Yes No

Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements have been made with the office manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

For Women

Are you pregnant? Yes No
What was the date of your last period? _____

Pain and Symptoms

Describe your pain and its location: _____

What was the cause of your present symptoms?

How long have you had this condition? _____
Have you had these symptoms before? Yes No
If yes, please explain: _____

Does your pain radiate to other areas? Yes No
If yes, where? _____

What aggravates your condition? _____

What relieves your condition? _____

Have you seen any other doctors for this condition?
 Yes No If yes, please explain: _____

Have you previously received chiropractic care? Yes No If yes,
how long since your last visit? _____
Are you interested in a maintenance program? Yes No

Medical History

Do you have any health problems? Yes No
 Heart Lungs Kidneys Thyroid Other
If yes, please explain: _____

Have you had any surgeries? Please explain _____

Have you had any broken bones or fractures? Yes No
If yes, please explain: _____

Have you had any accidents or traumas? Yes No
If yes, please explain with dates: _____

I authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer, diagnose, or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of
_____ have read and fully understand the above terms of
acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and
his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-
ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

(signature)

(date)

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**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I, _____ have read a copy of Zanetti Chiropractic, Inc's
(Patient name)

Notice of Patient Privacy Practices.

(Signature of Patient of
Parent or legal Guardian)

(Date)

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Patient Name: _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to ZANETTI CHIROPRACTIC, INC. of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to ZANETTI CHIROPRACTIC, INC.

Furthermore, I hereby IRREVOCABLY ASSIGN to ZANETTI CHIROPRACTIC, INC. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by ZANETTI CHIROPRACTIC, INC.

Authorization To Release Medical Record Information:

ZANETTI CHIROPRACTIC, INC., is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by ZANETTI CHIROPRACTIC, INC. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said ZANETTI CHIROPRACTIC, INC.

The undersigned certifies that He / She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of witness: _____

Signature of patient or responsible party _____