PATIENT INTRODUCTION FORM

RALPH M LEMONGELLO, DC

Please Print!

First Name **MI**	**Last Name:**
Home Address: Street:	**City:** **State:** **Zip:**
Birth Date: **Age:** **Sex: M / F**	**Home Telephone:**
Social Security No:	**Cell Phone:**
Height: **Weight:**	**Occupation:**
Marital Status: Single, Married, Divorced, Widowed	**Employer:**
Spouse's Name:	**Work Address:**
E-mail:	**Work Telephone:**
How Did You Choose Us? (If referred, please tell us by whom):	

Reason for Visit (Please tell us why you are here, be as detailed as possible)

Is this Visit Related to a:

Work Related Injury Sports/Recreational Injury Home Injury
Car/Vehicle Related Injury* School/Employment Exam Other (Describe):

**(If Car Accident, please provide details on a separate sheet or on back, & provide copy of accident report when ready.)*

Other Doctors Seen for Your Current Condition?

Have You Ever Been Treated by Another Chiropractor? Yes / No Name?

Do You Have Insurance?

Insurance ID #: **Group #:**

Insurance Company Name:	**Name of Primary Person Insured:** (Is this person: Yourself? Spouse? Parent?)
Primary Insured's Employer:	**Primary Insured's Address (*if different*):**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. **However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient (or Parent/Guardian) Signature: _____ **Date:** _____

Please Print! **Health Questionnaire** **Name:**

Have You Ever Had Surgery? (if so, please describe:)
Have You Ever Broken any Bones? (if so, where & when:)
Have You Ever Suffered a Falling Accident, Even as a Child (if so, please tell us when and how you fell)?
Have You Ever Had a Car Accident (if so, please tell us when and what you injured)?
Please List any Current Medical Conditions (if treated, please tell us how and with whom)?
Do You Have Any Allergies? (if so, please detail:)

Please List Current Medications:

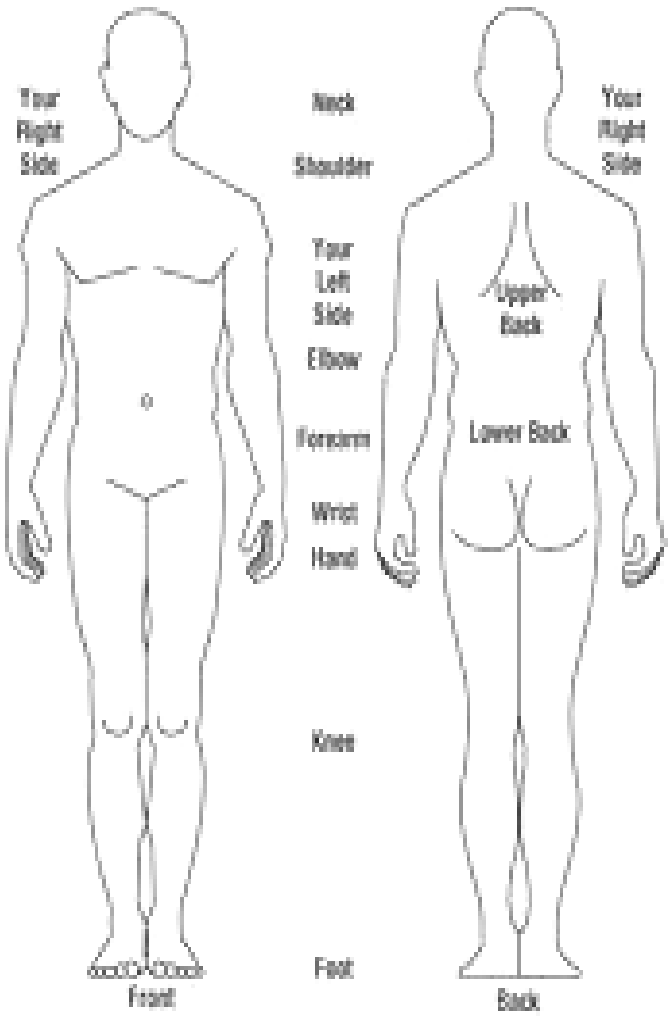
Date of Your Last Physical Exam?		**Is There a Chance You Are Pregnant?**	
Do You Experience Pain Every Day?	**Y/N**	**Does Your Pain Wake You Up at Night?**	**Y/N**
Do Your Experiences Interfere With Your Daily Life?	**Y/N**	**Are Symptoms Worse at Certain Times of Day?**	**Y/N**
Do Changes in Weather Affect Your Symptoms?	**Y/N**	**Do You Wear Orthotics?**	**Y/N**
What Activities Aggravate Your Symptoms:			

	None	**Light**	**Moderate**	**Heavy**
Do you Smoke?				
Alcohol?				
Caffeine?				
Exercise?				

Family History (Please list notable health conditions of parents, grandparents, siblings; for instance: heart disease, diabetes, cancer, etc.)

Please Provide an Emergency Contact: Name: **Relationship:** **Phone:**

Please Print! **Health Questionnaire** **Name:**



(After Printing, by hand please indicate **TYPE & LOCATION** of your symptoms:)

A = Ache **S** = Stabbing **SH** = Shooting **B** = Burning **P** = Pins & Needles **N** = Numbness **O** = Other

PATIENT ACKNOWLEDGMENT OF RECEIPT OF RALPH M. LEMONGELLO, DC NOTICE OF PRIVACY PRACTICES

BY SIGNING BELOW, I ACKNOWLEDGE RECEIVING A COPY OF **RALPH M. LEMONGELLO, DC** NOTICE OF PRIVACY PRACTICES, DATED 14 APRIL 2003, REV 25 JUNE 2007.

Patient's Name	Patient's Birthdate	Patient's Social Security #

Signature of Patient (or Personal Representative*)	Date

* IF SIGNED BY A PERSONAL REPRESENTATIVE, THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED:

Print Name of Personal Representative

Description of the Personal Representative's authority to act on behalf of the patient