Moskowitz Chiropractic

5415 W. Cedar Lane, Suite 105-B, Bethesda, MD 20814

Patient's name_____Date_____

SS#_____ Date of birth_____ Age_____

Address_____City_____State_____Zip_____

Status: Single_____ Married_____ Other_____ # of children_____ SEX: M__ F___

Home phone _____ Cell phone _____ Email address _____

Employed by_____ Business phone _____

Spouse's name_____Work phone_____

Were you referred to this office? Yes____No____ Who referred you?
_____

Health Insurance? Yes____No____Plan Name_____

Insured's name_____ID#_____

Insured's policy group #_____Insured's date of birth_____

In case of emergency whom may we contact_____Phone_____

Is patient's condition related to Employment? Yes____No____ Auto Accident? Yes____No____ Other Accident? Yes____No____

Reason for this appointment_____

Condition(s) / Symptoms / Pain you are currently experiencing_____

Has this happened before? Yes____No____ When was the first occurrence?_____

On a scale of 1-10 **(with 10 being the worst)**, rate the pain you are currently experiencing in your:
Neck_____ Mid-back_____ Low back_____ Other_____

Have you seen another doctor for this condition? Yes____No____
When?_____Doctor_____

Previous chiropractic care? Yes____No____
When?_____Doctor_____

Do other family members receive chiropractic care? Yes____No____
Who?_____

Previous spinal x-rays? Yes____ No____
When?_____Reason_____

Have you ever been in an auto accident? Yes____No____ When?_____Extent of Injuries_____

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Have you ever suffered a fall or serious injury? Yes____No_____ When?_____Extent of Injuries_____

Last physical exam date: _____ Previous surgery? Yes____No____ date_____Type of surgery_____

Do you smoke? Yes____No____ Do you exercise? Yes____No____ Are you pregnant? Yes____No____Possible____

List all medications presently being taken_____

Have you ever been diagnosed as having or suffering from (check all that apply)

__High/ Low Blood Pressure __Eating Disorder __Head Problems __Drug Addiction __HIV Positive __Osteoarthritis __Ulcers
__Circulatory Problems __Coughing Blood __Strokes __Gall Bladder __ Depression __Tumors
__Rheumatoid Arthritis __Seizures /Convulsions __Diabetes __Cancer __Pace Maker __Alcoholism
__A Congenital Disease __Excessive Bleeding __Ruptures __Epilepsy __Broken or Fractured Bones

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 care and treatment, any fees for professional services rendered to me will be immediately due and payable. Immediate payment is expected upon receipt of any statement from this office. Late payments may be subject to interest at the rate of 1 ½% per month (annual rate is 18%) or the maximum allowed by law, on the unpaid balance and all collection costs including all attorney fees. I hereby authorize the release of any medical or other information necessary to process any claims. I authorize payment of medical benefits to Michael N. Moskowitz, D.C., as my provider for any services. I further permit copies of this authorization to be used in place of the original.

Patient/Guardian signature_____ **Date**_____

PRIVACY PRACTICES ACKNOWLEDGEMENT – I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES.

Patient/Guardian signature_____**Date**_____