Dr. Sandra A. Licata
542 East Main Street| Batavia, NY 14020
Ph: (585) 343-5311 | Fx: (585) 343-2146

Confidential Patient Information

Date _______________

Name ______________________________ Birth date ___________ Age ________

Address ____ City _________________________ Zip Code_______________

Home Phone __________ Cell # __________________ E-Mail Address____

Marital Status M S W D # of Children_____________ Primary Physician __________________Phone_____________

Employer ____ Occupation____

Address____Office Phone__________________

Insurance ____Insured's Name_________________Birthdate______________

Name of Wife or Husband ______________________________Occupation _______________________________________

Employer ____Address ____

Patient's nearest relative ________________________Address __________________________ Phone__________________

Is condition due to Employment or Motor Vehicle Accident? _________________________Was a report Filed?___________

Date symptoms Appeared or accident happened ____

Patient ever had same or similar condition: Yes ☐ No☐ if yes, when and describe ___________________________________

____

Have you lost any days from work? ____

Date of last physical examination: _________________________ Female: Are you Pregnant?__________________________

Have you ever been under Chiropractic Care? Yes☐ No☐ Doctors Name____

Tingling or numbness in
☐Shoulders ☐Arms ☐Elbows ☐Hands
☐Hips ☐Legs ☐Knees ☐Feet

Are you currently using:
Nutritional supplements ☐Yes ☐No
Heel lifts or arch supports ☐Yes ☐No

Habits	Heavy	Moderate	Light	None
Alcohol	_____	_____	____	____
Coffee	_____	_____	____	____
Tobacco	_____	_____	____	____
Drugs	_____	_____	____	____
Exercise	_____	_____	____	____
Pop	_____	_____	____	____
Tea	_____	_____	____	____
Sweets	____	_____	____	____

Please Print
Purpose of this Appointment (Major Complaint) ____

____

What activities aggravate your condition? ____

Is this condition getting progressively worse ? ☐Yes ☐No ☐Constant ☐Comes and goes

Is this condition interfering with your ☐Work ☐Sleep ☐Daily Routine ☐Other

When did you first notice this problem? ______________________________

What makes your pain worse?______________________________
What makes your pain better? ______________________________

Other Doctors seen for this condition? ______________________________

Have you been treated for any health conditions by a physician in the last year? ☐Yes ☐No If Yes, please describe ____

Rate your Pain from 0-10 with a 10 being the worst pain ever

____
Is your pain sharp dull or radiating? Other?______________________________

What medications or drugs are you taking? ______________________________

Date of last X-ray ______________________________

Past History

Have you ever been in a motor vehicle accident? ☐Yes ☐No If Yes, please describe ______________________________

____

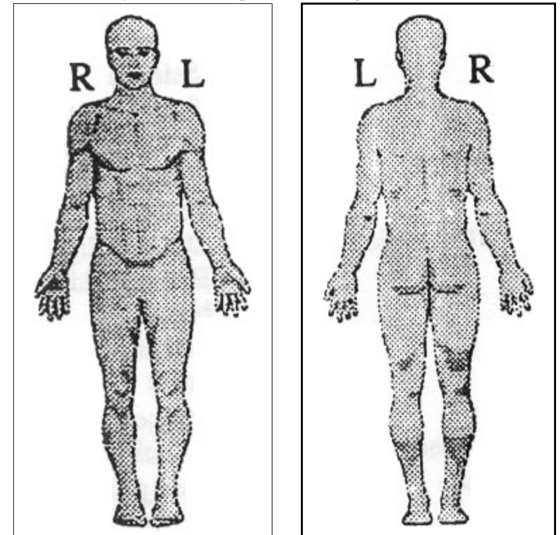
Have you suffered any fractures? ☐Yes ☐No If Yes, please describe ______________________________

____

What operations have you had? ______________________________

Serious Illness ______________________________

Please mark your areas of pain on the figures below



Family History
Please check if any of your immediate family has
Suffered from and indicate who.
☐Heart Disease ____________________
☐Arthritis ____________________
☐Cancer ____________________
☐Psychological Disorders ____________________
☐Serious Illness ____________________

Referred by ______________________________

Payment is expected at time of visit.

Name of person responsible for payment ______________________________

Are you insured? ☐**Yes** ☐**No Company** ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon 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 Signature ______________________________ Date ____________

Guardian or Spouse's Signature Authorizing Care ______________________________ Date ____________

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ASSIGNMENT OF BENEFITS

I authorize that payment be made directly to **DR. SANDRA A. LICATA** for any and all insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance companies or pre-paid health care plan will cover, or pay for all my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I understand that I am responsible for the copay, coinsurance or deductible set by my insurance company and is due at the time of service. Failure to pay at time of service may result in a service charge of $5.00. There will be a $25.00 fee for returned checks.

RELEASE OF INFORMATION

I authorize the release of any information concerning my health and health care services to my insurance company(s), pre-paid health plan(s), Medicare, employer, co-treating physician and/or referring physician. I authorize Licata Chiropractic including Dr. Licata or staff to text message me regarding appointments and anything related to my care.

AUTHORIZATION TO RELEASE INFORMATION

I hereby request and authorize you to furnish to DR. SANDRA A. LICATA, all records and reports, including x-rays and any other information they may request relating to any examination, treatment or opinion concerning my condition that I may have had in the past, now have or may have in the future.

ACKNOWLEDGMENET OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

RELEASE OF INFORMATION

I further authorize the release of any information concerning my health and health care services to the following designated individuals:

Designated Person: ____________________________ Relation to Patient: ____________________________

Address: ______________________________________ Phone: ____

Designated Person: ____________________________ Relation to Patient: ____________________________

Address: ______________________________________ Phone: ____

I have read and agree with ALL of the above statements of this form.

____ __________________________

Patient Signature or Guardian/Responsible Party Date

Why are you seeking treatment today?

____
____
____

Is this visit related to: (please check appropriate answer)

______ Auto accident
______Work related
______ Neither of Above

Current Medications:

____
____
____

Allergies and medical changes since last visit:

____
____
____

Please continue to the other side of the page.

Thank you for your cooperation

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Dr. Sandra A. Licata
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Batavia, NY 14020
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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 towards the same objective and understands basic terminology.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. **Health:** A state of optimal physical, mental and social well-being, not merely the absence of 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 to diagnose or treat any disease or condition other than vertebral subluxation. 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 a health care provider who specializes in that area. 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 a major interference to the spine and related areas.

Physical Therapy Burns: Heat generated by physical therapy modalities (Ultrasound), may cause minor burns to the skin. These are rare, but should be reported, as well as other side effects you may be experiencing.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I ________________________ have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Patient/Guardian Signature______________________________ Date _______________

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Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____________________________Birthdate_______________

Signature____

Date____