Dr. Gary T. Scardino | 319 South State Street, Newtown, Pa 18940 | 215-860-7275

Scardino Family Chiropractic Center

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information

Name: _____ Date: _____ SS/HIC/Patient ID#: _____
Address: _____ City: _____ State: _____ Zip: _____
Sex: ☐ Male ☐ Female Birthdate: _____ Email: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference
☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for ____ years
Patient Employer/School: _____ Occupation: _____
Employer/School Address: _____ City: _____ State: _____ Zip: _____
Spouse/Parent's Name: _____ Employer: _____ Work Phone: _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name of the person responsible for this account: _____
Relationship to Patient: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Employer: _____ Work Phone: _____

Insurance Information *(Please bring your insurance card to office)*

Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ Social Security#: _____ Date Employed: _____
Name of Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Co.: _____ Phone: _____ Group#: _____ Employer#: _____
Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____
DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of Insured: _____ Relationship to Patient: _____
Birthdate: _____ Social Security#: _____ Date Employed: _____
Name of Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Co.: _____ Phone: _____ Group#: _____ Employer#: _____
Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Symptoms

Reason for visit: _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain. (1 mild pain or discomfort, to 10 severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other: _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Bulimia	☐ Goiter	☐ Measles	☐ Polio	☐ Tuberculosis
☐ Alcoholism	☐ Cancer	☐ Gonorrhea	☐ Migraine Headaches	☐ Prostate Problems	☐ Tumors, Growths
☐ Allergy Shots	☐ Cataracts	☐ Gout	☐ Miscarriage	☐ Prosthesis	☐ Typhoid Fever
☐ Anemia	☐ Chemical Dependency	☐ Heart Disease	☐ Mononucleosis	☐ Psychiatric Care	☐ Ulcers
☐ Anorexia	☐ Chicken Pox	☐ Hepatitis	☐ Multiple Sclerosis	☐ Rheumatoid Arthritis	☐ Vaginal Infections
☐ Appendicitis	☐ Depression	☐ Hernia	☐ Mumps	☐ Rheumatic Fever	☐ Venereal Disease
☐ Arthritis	☐ Diabetes	☐ Herniated Disc	☐ Osteoporosis	☐ Scarlet Fever	☐ Whooping Cough
☐ Asthma	☐ Emphysema	☐ Herpes	☐ Pacemaker	☐ Stroke	☐ Other: _____
☐ Bleeding Disorders	☐ Epilepsy	☐ High Cholesterol	☐ Parkinson's Disease	☐ Suicide Attempt	_____
☐ Breast Lump	☐ Fractures	☐ Kidney Disease	☐ Pinched Nerve	☐ Thyroid Problems	_____
☐ Bronchitis	☐ Glaucoma	☐ Liver Disease	☐ Pneumonia	☐ Tonsillitis	_____

Date of last exams: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred:

_____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? ☐ Yes ☐ No How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on daily basis? _____

Certification & Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and or my dependent(s) have insurance coverage with _____name of insurance company and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Gaudian or Personal Representative Date