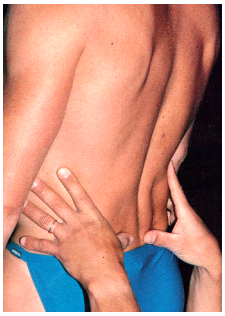


DUBARRY CHIROPRACTIC, INC.

11211 Prosperity Farms Road
Suite B204
Palm Beach Gardens, Fl 33410 USA
Tel: 561-622-9197
Fax: 561-622-4964
www.dubarrychiropractic.com

Patient General Information

CONFIDENTIAL

Name: _____ Date: _____

Address_____ Social Security # _____

Address_____ Marital Status _____

Date of Birth _____ Home Ph _____Cell Ph _____

Occupation _____ Work Ph _____ Pager _____

Email_____ Who sent you to our office? _____

Typical Body Position at Work: ☐ Varies ☐ Sitting ☐ Standing ☐ Others Describe:_____

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

Have you seen a Physical Therapist before? ☐ Yes ☐ No

Spouse Name _____ Spouse Occupation _____

Are you covered by Medicare? ☐ Yes ☐ No Your Insurance co. _____

Has your deductible been met, if any? ☐ Yes ☐ No ☐ I don't know

I do not have insurance & prefer to pay out-of-pocket. ☐ Yes ☐ No

Condition is due to a work accident? ☐ Yes ☐ No

Have you had a recent trauma? ☐ Yes ☐ No

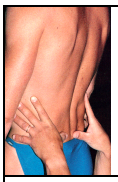
Have you had a car accident in the past? ☐ Never ☐ Month ☐ Year ☐ Over 2 years

When was your last physical? _____

Do you have a treating Physician? ☐ Yes ☐ No Physician's Name _____

Do you have an Urologist or OBGYN? ☐ Yes ☐ No Physician's Name _____

Thank you



Health Form

Confidential

Last Name		First Name		Today's Date	

Do you have or have you ever had any of the following?

☐ Alcoholism	☐ Gout	☐ Rheumatic fever
☐ Anemia	☐ Hypoglycemia	☐ Rheumatoid Arthritis
☐ Cancer	☐ Multiple sclerosis	☐ Ulcers
☐ Canker Soars	☐ Osteoarthritis	
☐ Diabetes	☐ Parkinson's disease	
☐ Epilepsy	☐ Pneumonia	
☐ Goiter	☐ Polio	

What is the health history of your immediate family?

Mother……
Father……
Grandparents……
Brothers……
Sisters……
Children……

What is your resistance to infections?

☐ Catch Cold Easily ☐ Have Frequent Sinus Trouble ☐ Your Gums Bleed Easily

System Review

Gastrointestinal: Do you or have you experienced?

☐ Constipation	☐ Diarrhea
☐ Blood in Stool	☐ Metallic taste in mouth
☐ Distress From Fat	☐ Hiatal hernia
☐ Nausea	☐ Vomiting
☐ Heartburns	☐ Recent Weight Gain
☐ Burning of the stomach relieved by eating	☐ Recent Weight Loss
☐ Burping or Bloating	

Cardiovascular: Do you or have you experienced?

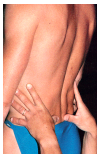
☐Pain in the heart	☐Shortness of Breath in exertion
☐Heart Attack	☐Low Blood Pressure
☐Swelling in Ankles	☐High Blood Pressure
☐Irregular Heartbeat	☐Pressure in the Chest
☐Stroke	

Nervous System: Do you or have you experienced?

☐ Dizziness/ lightheaded	☐ Memory loss
☐ Fainting	☐ Loss of coordination

Eye, Ear, Nose and Throat: Do you or have you experienced?

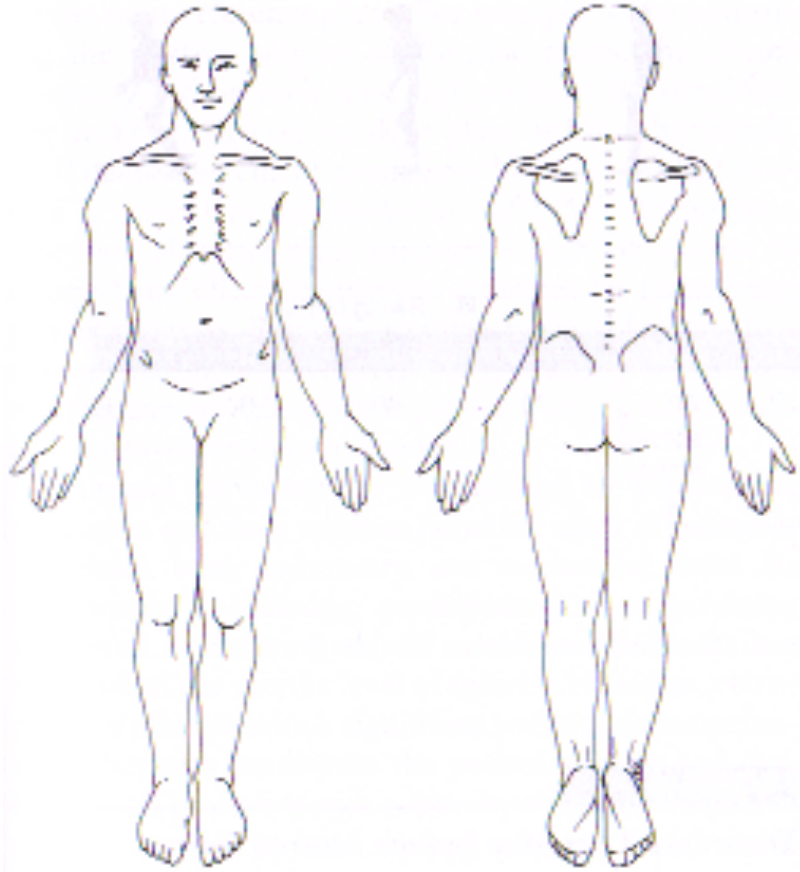
☐ Vision Problems ☐ Hearing Loss ☐ Ear Pain ☐ Ear Noises ☐ Dental Problems ☐ Nose Bleeding	☐ Difficulty Breathing Through Nose ☐ Difficult Speech ☐ Hoarseness ☐ Sore Throat	
Urinary Tract:		
☐ Blood in Urine ☐ Inability to Control Urination ☐ Painful Urination	☐ Bladder Infection ☐ Kidney Stones	
Respiratory		
☐ Chest Pain ☐ Spitting up Blood ☐ Spitting up Phlegm	☐ Difficulty Breathing ☐ Shortness of Breath ☐ Emphysema	☐ Allergies ☐ Asthma ☐ Chronic Cough
Women only:		
☐ Irregular period ☐ Menopausal Symptom ☐ Vaginal Discharge ☐ Lumps in Breast ☐ Premenstrual Depression	☐ Hot Flashes ☐ Menstrual cramps ☐ Excessive flow ☐ Painful Breast	☐ Nausea ☐ Spotting ☐ Hysterectomy ☐ Headaches with Period
Men only		
☐ Burning on Urination ☐ Difficulty Starting Urination ☐ Need to get up at Night to Urinate	☐ Feeling of Incomplete Bowel Evacuation ☐ Prostate Trouble ☐ Dripping after Urination	
List All the Surgeries You Have Had And List The Dates		
List Any Medication You Are Now Taking		
Do You Smoke? ☐ **Yes** ☐ **NO**	**How many packs a day…….** **For how many years……**	
What is Your Alcohol Intake?		
Patient's signature		



Area of complaint (initial visit)

Last name		First name		Today's date	

A **Circle Each Area of Complaint on the Chart Below**

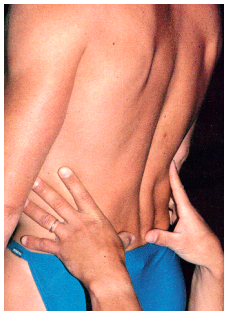


B Please answer the following questions about each area of pain you circled. If there is more than one area please number each area and fill out the additional sections. Sign and date on back.

Area #	
Pain Number (O none to 10 worst)	
What makes your pain feel worse?	
What makes your pain feel better?	
How long after the accident before the symptoms developed?	
Do you have pain (circle)	25% 50% 75% 100% of the day?
How many days a week do you have pain?	
Have you had prior complains in this area?	Yes No
If yes to the precedent questions explain	

C

Area #		Pain Number (O none to 10 worst)		
What makes your pain feel worse?				
What makes your pain feel better?				
How long after the accident before the symptoms developed?				
Do you have pain (circle)	25% 50% 75% 100% of the day?			
How many days a week do you have pain?		Have you had prior complains in this area?		Yes No
If yes to the precedent questions explain				



DUBARRY CHIROPRACTIC INC

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E-Mail: drdubarry@comcast.net

OFFICE POLICY

Dear Sir or Madam:

Our office policy is dedicated to your health. We have created this office policy to prevent misunderstandings.

1. For the first visit:

- If you carry regular health insurance and your coverage has been verified, you just need to pay your co-pay on every visit.
- If you carry regular health insurance and your coverage could not be verified right away, you need to pay the first visit in full then the co-pay on next visits. The money will be refunded with a check or will be applied towards your future co-pays when the first payment is received from the insurance company
- If you are a cash patient you pay your visits in full.

2. Most insurance plans pay for chiropractic services. If your insurance qualifies, we will bill your insurance company directly. However, all charges are your responsibility from the date the services are rendered. **(**If you are a Medicare, an automobile accident or a work injury patient this does not apply for you.)

3. In order to maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees.

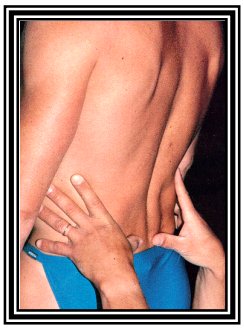
4. Collections: WHAT YOUR INSURANCE COMPANY DOES NOT PAY WITHIN 60 DAYS YOU MUST PAY. If collection proceedings become necessary, the patient or the one responsible for the payment, agree to be responsible for all attorney fees, court costs, or any other fees in the collection of debt.

5. Interest charge of 10% per year, will be added each month, to all 30 days past due accounts.

6. CANCELLATION OF APPOINTMENT MUST BE GIVEN 24 HOURS IN ADVANCE TO AVOID BEING CHARGED. NO-SHOW OR SAME DAY CANCELLATION FEE IS $25.00

7. I have read, understood and agreed to all of the above information.

Patient's signature ----------Date:----------



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FINANCIAL POLICY

Filing your insurance claims is a courtesy we extend to our patients and does not relieve you of the responsibility of your bill. Patients are responsible for payment of deductibles, co-payments or any other procedures that are not covered under the insurance contract. Payment is expected at the time of the visit. Billing department files your claims to your primary insurance company, therefore filing your medical claims to your secondary insurance company is solely your responsibility.

Patient's Signature: _____

ASSIGNMENT OF BENEFITS: I authorize payments of benefits to Dr. Etienne DuBarry for any service rendered.

Date: _____ Patient's Signature: _____

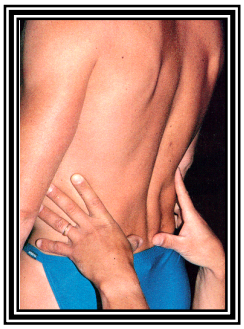
RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process my insurance claims.

Date: _____ Patient's Signature: _____

I understand and agree that I am responsible for the balance on my account for any professional services rendered, and I will notify this office of any changes in my insurance status.

Date: _____ Patient's Signature: _____

Please present your insurance card and a picture I.D. to the office staff.



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NOTICE OF PRIVACY PRACTICES

I have reviewed and understood Dr. Etienne DuBarry, D.C. Notice of Privacy Practices which describes how medical information about myself, or the patient that I am the representative of, may be used or disclosed and how I can get access to this information.

PATIENT'S NAME: _____

PATIENT I AM REPRESENTING: _____

SIGNATURE: _____

DATE: _____

…….I have read the Notice of Privacy Practices and refuse a hard copy at this time. I may request a hard copy at a later date.

Request copy of Notice of Privacy Practices:

.....Paper copy given in office.

…….US Mail to Address…….

……..