# WELCOME

## Suburban Chiropractic Associates

### Patient Information

Today's Date: ______________________________

Soc. Sec. #: ______________________________

Patient Name: ______________________________
Last

______________________________
First Middle Initial

Address: ______________________________

City: ______________________________

State: ______________ Zip: __________

E-Mail: ______________________________

Date of Birth: ______________

() Male () Female Age: ______________

() Married () Single () Widowed () Divorced () Separated

() Minor () Partnered for ______Years

Home Phone: ( ) ______________________________

Cell Phone: ( ) ______________________________

Employer: ______________________________

Employer Phone: ( ) ______________________________

Employer Address: ______________________________

Occupation: ______________________________

Spouse's Name: ______________________________

Spouse's Date of Birth: ______________________________

### Insurance Information

Who is responsible for this account? ______________

Relationship to Patient: ______________________

Ins. Co. ______________________________

Policy Number: ______________________________

Group #: ______________________________

*Subscriber (Policy Holder) Info if it is not You*

Name: ______________________________

D.O.B. ______________ SS#: ______________

Address: ______________________________

Primary Care Physician (PCP): ______________

PCP Address: ______________________________

Is Patient Covered By Additional Insurance? () Yes () No

### In Event Of Emergency

Who Should We Contact? ______________________

Relation: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Work Phone: ______________________________

### Accident Information

Is Condition Due To An Accident? () Yes () NO Date: __________ Type of Accident: () Auto () Work () Home () Other

Did You Report Your Accident? () Yes () No If Yes, To Whom? () Auto Ins () Employer () Worker Comp () Other

Attorney Name (If Applicable): ______________________________________________

### Reason For Visit

Reason for your visit: ______________________________________________

When did your symptoms appear? ______________________________________________

Is this condition getting better or worse? () Yes () NO Is the pain constant or come and go? ______________________

Does the pain interfere with your () Work () Daily Routine () Recreation () Sleep

Type of Pain: () Sharp () Dull () Throb () Ache () Numb () Tingle () Shooting () Pinch () Pressure

Where is the pain? ______________________ Pain Level 0 (No Pain) to 10 (Worst Pain Ever) ______________________

### Assignment And Release

I certify that I, and/or my dependent(s), have insurance coverage with (Ins Co)______________ and assign directly to Dr. Acquisto all 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 and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

**Signature of Patient/Guardian** ______________________________ **Relationship to Patient** ______________

**Date** ______________ **Print name of Guardian** ______________________________

**HABITS:**

| | | |
|---|---|---|
| Did/Do you smoke? | Y / N | ______ |
| Did/Do you drink alcohol? | Y / N | ______ |
| Exercise Regularly? | Y / N | ______ |
| Eye Problems? | Y / N | ______ |
| High Stress Levels? | Y / N | ______ |
| Have you been in any accidents/trauma? | Y / N | ______ |
| Sports Injuries? | Y / N | ______ |
| Do you sleep well, hours of sleep? | Y / N | ______ |

Name & address of doctors who have treated you: ______

What activities make condition feel better? ______
What activities make condition feel worse? ______

**WORK ACTIVITY:**

() Sitting () Standing () Light Labor () Heavy Labor

**FEMALE ONLY:**

Are You Pregnant? () Yes () No Due Date: ______

| **INJURIES/SURGERIES You Have Had** | **Description** | **Date** |
|---|---|---|
| Falls | ______ | ______ |
| Broken Bones | ______ | ______ |
| Head Injuries | ______ | ______ |
| Surgeries | ______ | ______ |

**Please Mark Any Of The Following Conditions You Have Now Or Have Had In The Past:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | () | Cataracts | () | High Cholesterol | () | Headache | () |
| Alcoholism | () | Chicken Pox | () | Kidney Disease | () | Psychiatric Care | () |
| Allergy Shots | () | Diabetes | () | Liver Disease | () | Rheumatic Fever | () |
| Anemia | () | Emphysema | () | Measles | () | Stroke | () |
| Appendicitis | () | Fractures | () | Multiple Sclerosis | () | Tuberculosis | () |
| Arthritis | () | Glaucoma | () | Osteoporosis | () | Tumors/Growths | () |
| Asthma | () | Gout | () | Pacemaker | () | Ulcers | () |
| Bleeding Disorder | () | Heart Disease | () | Parkinson's | () | SexuallyTransmitted Infxn | () |
| Bowel/Bladder | () | Hepatitis | () | Polio | () | Thyroid | () |
| Bronchitis | () | Hernia | () | Prostate Problem | () | High Blood Pressure | () |
| Cancer | () | Herniated Disc | () | Prosthesis | () | Miscarriage | () |
| Epilepsy | () | Herpes | () | Eating Disorders | () | | |
| Rheumatoid Arthritis | () | Pneumonia | () | Other:______ | | | |

**MEDICATIONS**

______ ______ ______ ______ ______

**VITAMINS**

______ ______ ______ ______ ______

**ALLERGIES:**

______ ______ ______ ______ ______

**FAMILY HISTORY** ___ Auto-immune Disorder ____Cancer ____Diabetes ____G.I. ____High Blood Pressure ____Heart Disease ____Kidney Disease ____Lung Disease ____Seizure Disorder ____Stroke ____Thyroid Disorder _____Other: ______

***Patient Name***: ______ ***Signature:*** ______ ***Date:*** ______

**Authorization to Call, Text, E-mail**

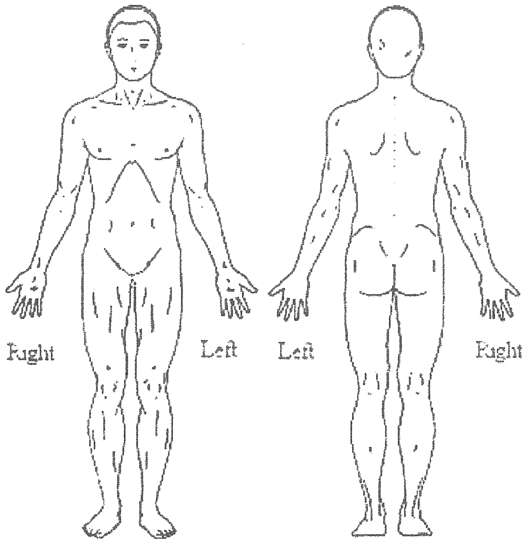
I authorize the office and the doctors of Suburban Chiropractic Associates to contact all phone numbers, including text messages and email addresses listed on file. In addition, I am requesting appointment reminder calls or other non-personal matters to be sent via text/email to the following:

PRINTED PATIENT NAME: ______
TEXT: Cell Phone: ( )______ Cell Phone Carrier: ______
E-mail Address: ______

_______ I choose not to be contacted by _____Email, _____ TEXT, or _____email/text. I may withdraw this authorization at anytime by submitting in a request in writing to this office.

Patient Name ___________________________________________________________

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.




Numbness N

Dull Ache A

Burning B

Sharp/Stabbing S

Pins, Needles P

Other ______ O

Please circle the appropriate number that corresponds to the pain level that you are **CURRENTLY** experiencing.

1. My pain when it is at its worst is:

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

2. My pain when it is at its least is:

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

3. My average pain level is:

   No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient
Signature______________________________________________Date______________________

# Back Index

Form BI100

rev 3/27/2003

**Patient Name** ______________________ **Date** ____________

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

### Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

### Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

### Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

### Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

### Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

### Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

### Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

### Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

### Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

### Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

# Neck Index

Form N1-100

rev 3/27/2003

**Patient Name** ______________________ **Date** ____________

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

## Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

## Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

## Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

## Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

## Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

## Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

## Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

# NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

| WCB CASE NO. (If Known) | CARRIER CASE NO. (If Known) | DATE OF INJURY | NATURE OF INJURY OR ILLNESS | INJURED PERSON'S SOC. SEC. NO. |
|---|---|---|---|---|
| | | | | |

| | | |
|---|---|---|
| CLAIMANT | NAME | ADDRESS APT. NO. |
| EMPLOYER | | |
| INSURANCE CARRIER | | |

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_______________________________________ Date ______________

Provider's Name and Address ____________________________________________________

_____________________________________________________________________________

**TO THE CLAIMANT**

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

**Workers' Compensation Law Section 32**

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

**TO THE HEALTH CARE PROVIDER**

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

Workers' Compensation Board

# Employee Claim

**C-3**

*State of New York - Workers' Compensation Board*

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): ______________________

## A. YOUR INFORMATION (Employee)

1. Name: ______________________ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: ______________________ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___-___-___ 5. Phone Number: (____)__________ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? __________

## B. YOUR EMPLOYER(S)

1. Employer when injured: ______________________ 2. Phone Number: (____)__________

3. Your work address: ______________________ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: ______________________

6. List names/addresses of any other employer(s) at the time of your injury/illness: ______________________

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

## C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? ______________________

2. What types of activities did you normally perform at work? ______________________

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: __________

4. What was your gross pay (before taxes) per pay period? __________ 5. How often were you paid? __________

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: __________

## D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: __________ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) ______________________

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? ______________________

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) ______________________

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) ______________________

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): ______________________



THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

YOUR NAME: ____________________ (First / MI / Last) DATE OF INJURY/ILLNESS: ___/___/___

## D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? ________

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): ________
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: ________

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: ________ ☐ orally ☐ in writing Date notice given: ___/___/___

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown **If yes, list names:** ________

## E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ___/___/___ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ___/___/___ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? ________ How often are you paid? ________

## F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ___/___/___ ☐ **None received (skip to question F-5)**
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your **injury/illness?** ☐ **none received** ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ **Hospital Stay over 24 hours**
   Name and address where you were first treated: ________
   ________ Phone Number: (___)________
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: ________
   ________ Phone Number: (___)________
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   ________
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

**I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.**

**Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.**

Employee's Signature: ________ Print Name: ________ Date: ___/___/___

On behalf of Employee: ________ Print Name: ________ Date: ___/___/___

***An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.***

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): ________ Date: ___/___/___

Print Name: ________ Title: ________

ID No., if any: R ________ If Licensed Representative, License No.: ________ Expiration Date: ___/___/___

Suburban Chiropractic Associates
220 Highland Pkwy.
Tonawanda, NY 14223
Ph: 716-874-2040 Fax: 716-799-1090

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

**Patient Name:** ______________________________________________

**Date of Birth:** ____________________

**Patient Address:** ______________________________________________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form to Dr. Acquisto and/or Suburban Chiropractic Associates:

[ ] Re-evaluation Reports: ____________________

[ ] Imaging Reports: ____________________

[ ] Test Results: ____________________

[ ] Medical Records From: __________ To: __________

[ ] Other: ____________________

**AUTHORIZATION TO DISCUSS HEALTH INFORMATION:**

* By initialing here, ________, I authorize Dr. Acquisto and/or Suburban Chiropractic Associates
*Initials*
To discuss my health information with the following checked individuals:

[ ] Primary Doctor: ______________________________________________

[ ] Family Members: ______________________________________________

[ ] Attorney: ______________________________________________

[ ] Specialists: ______________________________________________

[ ] Other: ______________________________________________

______________________________ ____________________
*Signature of patient or representative authorized by law.* *Date*