



DeLanzo Chiropractic Center
701 West Ave, Suite 202 ▪ Ocean City, NJ 08226
Phone: (609) 399-4717 ▪ Fax: (609) 399-2561

Patient Health Assessment

Please PRINT or WRITE CLEARLY

General Information

Patient Name: _____ Today's Date: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Summer Address (if different): _____

City: _____ State: _____ Zip: _____

Nickname: _____ Social Security #: _____

Home #: (____) _____ Work #: (____) _____ Cell #: (____) _____

Marital Status: _____ Date of Birth: _____ Patient Sex: M F

Email: _____

We will only use your email address to send appointment reminders. It will not be shared with any third parties.

Patient Employer: _____ Occupation: _____

Primary Care Physician's Name/Number: _____

How did you find out about us? _____

Insurance Information

Insurance Company Name: _____

Subscriber Name: _____ Relation to Patient: _____

Subscriber Date of Birth: _____ Employer: _____

Subscriber Address: _____

Insurance ID#: _____ Group #: _____

Secondary Insurance Company Name (if applicable): _____

Subscriber Name: _____ Relation to Patient: _____

Subscriber Date of Birth: _____ Employer: _____

Subscriber Address: _____

Insurance ID#: _____ Group #: _____



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Patient Name: _____

PLEASE CHECK ALL THAT APPLY TO YOU

ALLERGIES

- | | | | | |
|--|---|---|---|--------------------------------------|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Latex | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> X-Ray Dye |
| <input type="checkbox"/> Aspirin/Pain Medication | <input type="checkbox"/> Dissolvable Stitches | <input type="checkbox"/> Molds | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bee Sting | <input type="checkbox"/> Dust | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Soaps | _____ |
| <input type="checkbox"/> Chocolate/Sweets | <input type="checkbox"/> Eggs | <input type="checkbox"/> Ragweed/Pollen | <input type="checkbox"/> Sulfa Drugs | _____ |
| | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Rubber | <input type="checkbox"/> Wheat | <input type="checkbox"/> None |

SURGERIES

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Elbow | <input type="checkbox"/> Knee | <input type="checkbox"/> Oral | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Foot | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Perinatal Cyst | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Back | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Lumbar Disc | <input type="checkbox"/> Podiatric | <input type="checkbox"/> Wrist/Hand |
| <input type="checkbox"/> Brain/Tumor | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Prostate | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Gynecological | <input type="checkbox"/> Lymph Node Biopsy | <input type="checkbox"/> Shoulder | _____ |
| <input type="checkbox"/> Cervical Disc | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Thoracic Disc | _____ |
| <input type="checkbox"/> Cyst Removal Skin | <input type="checkbox"/> Hernia | <input type="checkbox"/> Neck | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Disc | <input type="checkbox"/> Hip | <input type="checkbox"/> Neurological | <input type="checkbox"/> Thyroid | _____ |
| <input type="checkbox"/> EENT | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Obstetrical | <input type="checkbox"/> Urology | <input type="checkbox"/> None |

MEDICAL HISTORY

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Ehlers Danlos Syndrome | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye/Vision Problems | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Sprain/Strain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke/Heart Attack |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcer/s |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Genetic Spinal Disorder | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Pre-Diabetes | <input type="checkbox"/> Wrist Pain |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Respiratory Condition | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Shoulder Pain | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Significant Weight Change | _____ |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Sinus Condition | <input type="checkbox"/> None |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | | | |

HABITS

- Tobacco use: None Past Present Occasional Moderate Heavy
- Alcohol use: None Past Present Occasional Moderate Heavy
- Caffeine use: (*coffee, tea, soft drinks*) None Past Present Occasional Moderate Heavy
- Pregnancy: None Past Present Due Date _____

MEDICATIONS

Reason for Usage

_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Condition

_____	_____
_____	_____
_____	_____

Patient Signature: _____

Date: _____



Dr. Ronald A. DeLanzo Jr.
701 West Ave Suite 202
Ocean City, NJ 08226
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Please circle pain levels 0-10 (10 being most painful) and circle type of pain.

Pain Levels: Neck Pain: 0 1 2 3 4 5 6 7 8 9 10
Type of Pain: Dull-achy, stiff, sharp, burning, numbness

Buttocks: 0 1 2 3 4 5 6 7 8 9 10
Dull-achy, stiff, sharp, burning, numbness

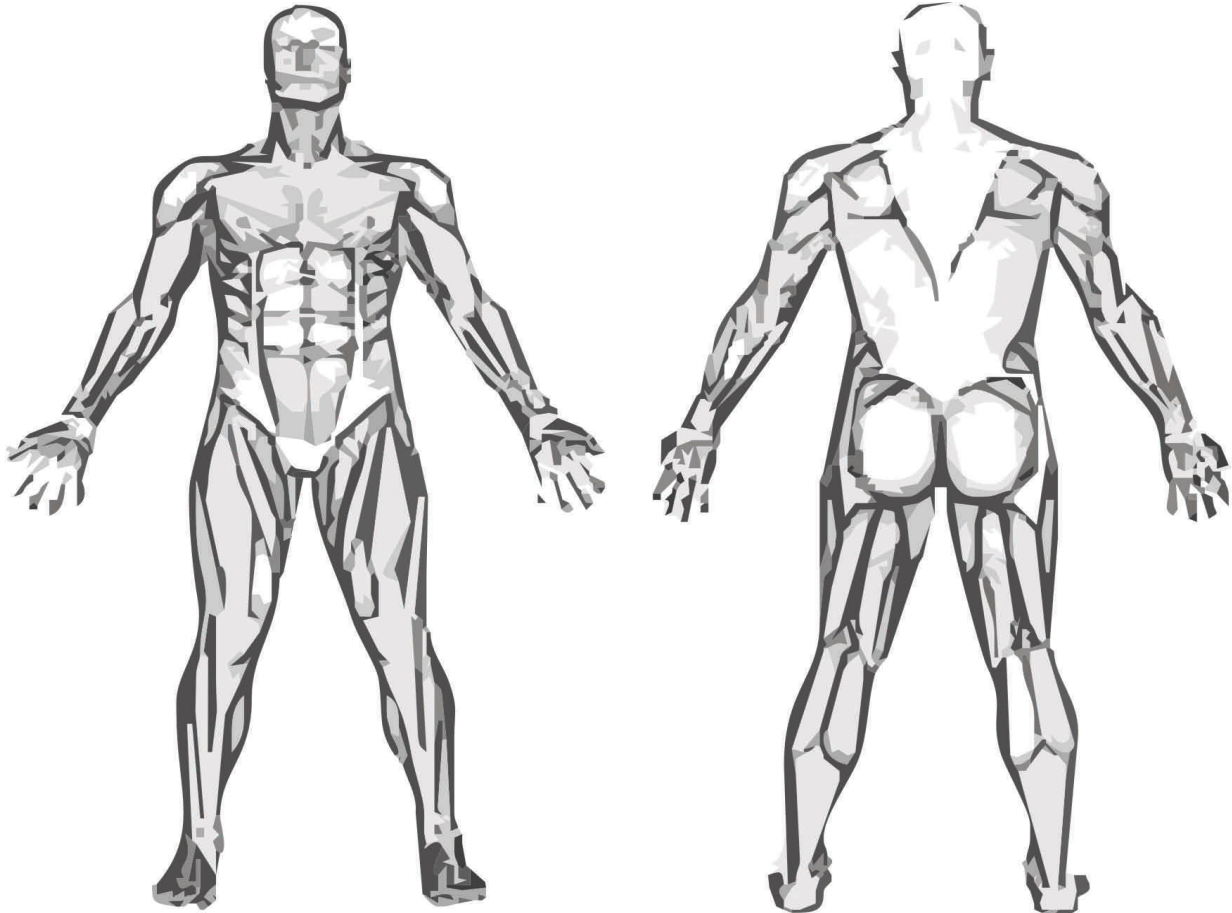
Pain Levels: Mid Back: 0 1 2 3 4 5 6 7 8 9 10
Type of Pain: Dull-achy, stiff, sharp, burning, numbness

Hip Pain: 0 1 2 3 4 5 6 7 8 9 10
Dull-achy, stiff, sharp, burning, numbness

Pain Levels: Low back: 0 1 2 3 4 5 6 7 8 9 10
Type of Pain: Dull-achy, stiff, sharp, burning, numbness

Shoulder: 0 1 2 3 4 5 6 7 8 9 10
Dull-achy, stiff, sharp, burning, numbness

Please mark "X" where you have pain on picture below



Patient Signature: _____

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Patient Consent Form

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Signature: _____

Date: _____

Consent for Treatment

I, the undersigned, hereby authorize Dr. Ronald DeLanzo and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient Signature: _____

Date: _____

Authorization to Release Medical Information

I authorize Dr. Ronald DeLanzo to release any medical information pertinent to my treatment plan to other medical providers that I deem necessary. This authorization for release of information shall remain valid unless I notify this office in writing. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient Signature: _____

Date: _____

Request for Payment of Benefits to Provider of Care

I hereby authorize my insurance company/insurance administrator to pay by check, and for it to be mailed directly to this office. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient Signature: _____

Date: _____

Consent for Treatment of a Minor

I hereby authorize Dr. Ronald DeLanzo and whomever he may designate as his assistant(s), to perform diagnostic tests. Including, but not limited to radiographs, and to administer treatment as he deems necessary to my (relationship of child) _____ (child's name) _____.

Guardian's Signature: _____

Date: _____

X-Ray/Medical Release

I have requested the release of records of (patient's name) _____ which are part of the records at (facility) _____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to (name) _____ (address) _____.

Patient Signature: _____

Date: _____