**Frank R. Stiso, DC, LLC**
**1903 Atlantic Avenue, Wall NJ 08736**

**Stiso Chiropractic Centers**
**Confidential Case History**

Date:__/__/__ Name _____ Address _____

City_____ State___ Zip_____ Soc.Sec.#___-____-____ Birthday: __/__/__ Age:_____

Marital Status: S or M Spouse's Name:_____ Spouse/Emergency Contact#: (___)_____

Height:_____ Weight:___ Occupation:_____ Job duties:_____

Employer (name/ address): _____ Spouse's Employer_____

Home Phone (___)_____ Work (___)_____ Cell (___)_____ Email:_____

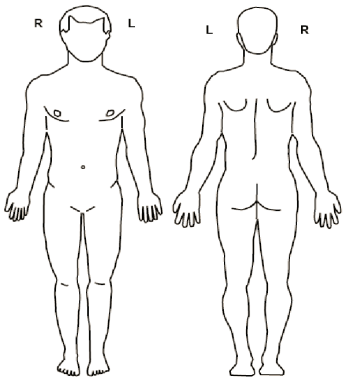
Allow Text Message Reminders: **Y** or **N.** Phone messages may include my personal health info (ex. Test results): **Y** or **N**

How did you hear about our office? ☐ Referred by PCP ☐ Insurance Booklet ☐ Friend _____
☐ Search Engine ☐Yellow Pages ☐ Newspaper/TV Ad ☐ Website / Internet ☐ Other _____

What is your major complaint? _____

Describe your symptoms in detail:_____

**Place an X over area(s) of pain ➔**




When & How did it occur? _____

Other Dr.'s seen for this condition:_____

Is this a work or automobile injury? **Y** or **N.** If yes, EXPLAIN: (date & place..etc)

_____

Rate your pain on a scale from 1-10 (Circle One) **10 = Most Painful** **1 2 3 4 5 6 7 8 9 10**

Pain wakes you up at night? **Y** or **N** Any unexplained weight loss/gain? **Y** or **N** Any dizziness/ fainting? **Y** or **N**

**Check those that best describe your condition:**

| | | |
|---|---|---|
| ☐ Dull | ☐ Numb | ☐ Burning |
| ☐ Sharp | ☐ Migraine | ☐ Electric Shock-like |
| ☐ Achy | ☐ Cramping | ☐ Constant |
| ☐ Stiff | ☐ Knifelike | ☐ Comes & Goes |

**Your past medical history. Mark all that apply:**

| | |
|---|---|
| ☐ Cancer | ☐ Hypertension |
| ☐ Diabetes | ☐ Heart disease/Stroke |
| ☐ Kidney disease | ☐ HIV |
| ☐ Musculoskeletal disorders | ☐ **Spinal surgery** |

Primary Care Doctor Name & Address: (*REQUIRED)_____

Past major surgeries, broken bones, illnesses etc: _____

_____

Previous Chiropractic Physician: (Name & Address):_____

List your current medication(s): _____

_____

**FEMALE PATIENTS ONLY:**

Are you currently or do you have any reason to believe you are pregnant? **Y** **N.** Has it been more than 10 days since the start of your last menstrual cycle? **Y** **N**. How many children have you birthed_____? Did you receive an epidural? **Y** **N**. Were there any complications during labor? **Y** **N**. If yes please explain:_____

_____

## HEALTH INSURANCE INFORMATION:

Primary Insurance Name:_____ Policy #:_____

Name of insured & date of birth?_____ Relationship to insured?_____

Secondary Insurance Name:_____ Policy #: _____

Name of insured & date of birth?_____ Relationship to insured?_____

## CHIROPRACTIC COVERAGE RESPONSIBILTY & REFERRALS:

You the patient are responsible for checking with your insurance company to verify chiropractic coverage before treatment begins. Our staff will also call your carrier to verifying coverage. However verification of coverage is not a guarantee of payment. **If you, or our staff, receive inaccurate coverage details from your insurance carrier you the patient are still financially responsible for ALL services rendered.** In addition, patients are responsible for obtaining all referrals (if needed). Referrals must be presented to the front desk before you are seen by the doctor. DO NOT expect your primary care physician to "back-date" your referral. If treatment is not covered by your insurance because a referral was not obtained, you the patient will be responsible for payment.

**Co-Payments are due at the time chiropractic services are rendered. Insurance companies forbid the waiving of deductibles or co-payments by healthcare providers. Co-Insurance must be paid in full.**

## MEDICARE PATIENTS: ADVANCED BENEFICIARY NOTICE (ABN)

Medicare only pays for the chiropractic adjustment. **Medicare does NOT pay for chiropractic physical examinations, X-rays or adjunctive physiotherapies** such as, but not limited to, electric muscle stimulation, ultrasound, cold laser therapy, traction… etc. The fact that Medicare will not pay for certain services does not mean that you should not receive them. By signing this case history, you accept financial responsibility for any non-covered services rendered by Dr. Stiso.

**ASSIGNMENT OF BENEFITS:** I understand that health and auto accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me and/or my attorney (if applicable, charges may apply). In making collection or settlement from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I irrevocably authorize, direct and instruct my attorney (if applicable) to make payment to Dr. Stiso from my settlement, fees due, to his office as mandated within the PIP fee schedule. Furthermore I authorize assignment of benefits to this office and allow Dr. Stiso and staff the right to appeal any claim denials from my insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am ultimately responsible for payment.

Furthermore, I understand that if I am accepted as a patient at the Stiso Chiropractic Center, I am authorizing Dr. Stiso to proceed with any standard treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request. I am aware it is my responsibility to make it known, or to learn through health care procedures, the existence of underlying conditions that would otherwise not come to the attention of the treating chiropractor. Conditions include, but are not limited to: latent pathological defects, skin damage, illnesses or deformities.

**I hereby attest all information given is true and agree to all office policies listed above.**

Patient's Signature_____ Date: _____

Guardian's or Spouse's Signature:_____ Soc. Sec. #:_____

## BELOW IS FOR OFFICE USE ONLY

**Additional Notes:** **CD9 Codes:**

99201 99202 99203 99204

72040 72070 72100 72114