Ferrigno Healthcare

2554 West Palmetto Street Florence, SC 29501 (843) 662-2110 Fax (843) 662-1991

Date: _____

Chart #_____

Full Name: _____ Sex: Male Female Marital Status: S M D W

Date of Birth: _____ Social Security #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone #: _____ Work Phone #: _____

Primary number for appointment reminders/communication #: _____

Emergency Contact: _____ #: _____

Employer Name: _____ Employer Phone #: _____

Employer Address _____ City: _____ State: _____ Zip: _____

☐ CHECK HERE TO DECLINE ANSWERING THE FOLLOWING 3 QUESTIONS

1) **My preferred language is:**
   - A. English
   - B. Spanish
   - C. Other _____

2) **My race is: (please circle one answer)**
   - A. American Indian/Alaskan Native
   - B. Asian
   - C. Black or African American
   - D. Native Hawaiian or Pacific Islander
   - E. White/Caucasian
   - F. Other _____

3) **My Ethnicity is: (please circle one answer)**
   - A. Hispanic or Latino
   - B. Not Hispanic or Latino

(Information about Your Parent/Spouse)

Parent/Spouse's Full Name: _____ Parent Phone Number: _____

Parent's Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance to File

Insurance Co. Name: _____ Relationship to Patient: _____

Insured's DOB: _____ Insured's Social Security # _____

Insurance Card ID #: _____ Group #: _____

Insured's Address (if different from patient): _____

Secondary Insurance

Insurance Co. Name: _____ Relationship to Patient: _____

Insurance Card ID#: _____ Group #: _____

Insured's DOB: _____ Insured's Social Security # _____

I understand that payment is due at the time services are rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any provider involved in my healthcare. I realize that this authorization gives Ferrigno Family Chiropractic, Inc., dba Ferrigno Healthcare to release any information to any of my insurers or providers as requested by any such insurer or provider. **I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, GROUP POLICY BENEFITS AND OTHER HEALTH PLANS TO FERRIGNO FAMILY CHIROPRACTIC,INC., DBA FERRIGNO HEALTHCARE. I HEREBY AGREE TO PAY ALL COSTS AND REASONABLE FEES IN THE EVENT THIS ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY.** If my insurance requires a referral or prior authorization, it is my responsibility to make sure it has been done prior to my appointment or test.

CANCELLATION/NO SHOW POLICY

We understand at times and for various reasons appointment must be cancelled and rescheduled. **If an appointment is not cancelled in at least 24 hours in advance you may be charged a $25.00 fee; this will not be covered by your insurance company.**

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Patient's Name _____ Date _____

In case of emergency you can contact:

Name	Relationship to Patient	Contact Number
Name	**Relationship to Patient**	**Contact Number**

Please list your **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea)

Please provide your **IMMUNIZATION HISTORY:**

	Yes	No	Date		Yes	No	Date
Tetanus-Diphtheria Booster				Hepatitis A Vaccine			
Influenza Vaccine (Flu Shot)				Hepatitis B Vaccine			
Pneumococcal Vaccine				Human Papilloma Virus (HPV)			
Tuberculosis (TB) Skin Test				Varicella Vaccine			

Please provide your **PAST MEDICAL HISTORY:**

____ Allergies
____ Anemia
____ Angina (chest pain)
____ Anxiety
____ Arthritis
____ Asthma
____ Atrial fibrillation
____ BPH (enlarged prostate)
____ Blood clots
____ Cancer, type_____
____ CVA (stroke)
____ COPD (emphysema)
____ CAD (hear disease)
____ Crohn's disease
____ Depression
____ Diabetes
____ Gallbladder disease
____ GERD (reflux)
____ Hepatitis C
____ High cholesterol
____ High blood pressure
____ Irritable bowel disease
____ Liver disease
____ Migraine headaches
____ MI (heart attack)
____ Osteoarthritis
____ Osteoporosis
____ Peptic ulcer disease
____ Renal disease (kidneys)
____ Seizure disorder
____ Thyroid disease

Please tell us about any **SURGERIES** you have had, you may indicate the **date/year if known:**

____ Angioplasty
____ Angioplasty with stent
____ Appendix
____ Arthroscopy knee
____ Back Surgery
____ CABG (open heart surgery)
____ Carpal tunnel release
____ Cataract
____ Cholecystectomy (gallbladder)
____ Cholectomy (colon removed)
____ Colostomy
____ Gastric bypass
____ Hernia repair
____ Hip replacement
____ Knee replacement
____ LASIK
____ Liver biopsy
____ ORIF (repair broken bone)
____ Pacemaker
____ Small bowel resection
____ Thyroidectomy
____ Tonsillectomy

Gender Specific Male:
____ Prostatectomy
____ TURP
____ Vasectomy

Gender Specific Female:
____Breast augmentation
____ Bilateral tubal ligation
____ Breast biopsy
____ Cesarean section
____ D & C
____ Hysterectomy
____ Mastectomy
____Breast reduction

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY:**

_____

Please provide your **FAMILY HISTORY:**

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Alcoholism					
Allergies					
Alzheimer's disease					
Asthma					
Blood disease					
Coronary artery disease (heart disease)					
Premature heart disease (male < 55 yr, female < 65 yr)					
Cancer, Type _____					
CVA (Stroke)					
Depression					
Developmental delay					
Diabetes					
Eczema					

	Mother	Father	Sister	Brother	Other
Hearing deficiency					
High cholesterol					
High blood pressure					
Irritable bowel disease					
Learning disability					
Mental illness					
Migraines					
Obesity					
Osteoarthritis					
Osteoporosis					
Peripheral vascular disease (Blood clots)					
Renal (kidney) disease					
Seizure disorder					
Other:					

Please provide your **SOCIAL HISTORY:**

Do you Smoke? Yes No Former
Type of tobacco: _____
Packs per day: _____
Years smoked: _____
Year Quit: _____
Have you ever tried to quit? Yes No

Do you drink Alcohol? Yes No Former
Type of alcohol: _____
Frequency: _____
Amount: _____
When was your last drink? _____

FOR FEMALES ONLY:

Age at First Period: _____
Date of Last Menstrual Period: _____
Date of Last Mammogram: _____
Date of Last Pap Smear: _____
Any history of abnormal pap smears? Yes No
If Yes, When: _____

Are periods regular? Yes No
Do you have pain with period? Yes No
Is Flow: Normal Heavy Light Spotting

Number of Pregnancies: _____
Number of Live Children: _____
Number of Miscarriages: _____
Number of Abortions: _____

FERRIGNO HEALTHCARE

Name _____ **Date** _____

Consent for Care

I give my permission to the provider/providers of FFC Inc. dba Ferrigno Healthcare to examine, perform tests, x-rays, etc., evaluate and treat me in accordance to their scope of practice in SC.

I have read and understand this statement.

_____

Patient's Signature Date

_____

EMR Usage

I am fully aware that this practice uses EMR, electronic prescribing with integrated lab and test results.

_____

Patient's Signature Date

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my medical records are protected under State and Federal confidentiality regulations. If our staff needs to discuss your care, test result, the scheduling of a test, referral, etc., are there any members in your family or household that we can discuss your medical information with? _____Yes _____No
If yes, please understand that they may request your Protected Health information along with your financial information.

_____

Name Relationship Date of Birth Contact Number

_____

Name Relationship Date of Birth Contact Number

OR _____ I DO NOT WANT MY MEDICAL OR FINANCIAL INFORMATION OT BE DISCUSSED WITH ANYONE.
At my request I authorize this practice to release my protected health information via:

_____ Leave detailed message on phone, mail, email, or patient portal.

_____ Leave message at home with call back number only.

_____ Leave message at work with call back number only.

_____ Leave detailed message at work on voice mail.

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Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Ferrigno Healthcare or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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Florence, SC 29501
(843) 662-2110

Fax (855) 650-3714

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To All Physicians, Hospitals and Other Health Care Providers Who Have Provided Care, Treatment or Services and/or Insurance Companies Who Have Provided Benefits to the following patient:

I hereby authorize Ferrigno Healthcare, and persons acting on its behalf, to receive information, and examine and receive copies of all records of every sort and kind, regarding the medical status of the patient named below. Such information and records are required in order to evaluate the condition of the patient. A photocopy of this authorization is to be considered as effective and valid as the original.

I understand that the medical information and records disclosed pursuant to this authorization may be redisclosed by the receiving entity for any lawful purpose, and thereafter, may no longer be protected by federal law privacy rules. I understand this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. However, I understand that any such revocation will not have any effect on any actions the providing entity took prior to receiving the revocation. If not earlier revoked, this authorization shall terminate upon settlement of all claims relating to the accident referred to above. Upon my request, I may see and copy the medical information described on this form.

Patient:_____ Date of Birth:_____

Signature:_____ Date_____