DEMA Rehab & Injury Clinic Inc.

Dr Ouadi Hassine DC.

1 - PATIENT INFORMATION:

$ame:_____ **Phone**_____ **date**_____
Address:_____ **ZIP**_____
Your Social Security #:_____ **Birth date:**_____
Ht.:_____ **WI.:**_____ **Marital Status:**_____
Occupation:_____ **Employed by:**_____ **Phone:**_____
Regular Health Insurance:_____ **Secondary:**_____ **E-mail**_____
Insurance ID:_____ **Ins Group #**_____ **Responsible $ame (if not the patient)**_____
Last Physician:_____ **Address** _____

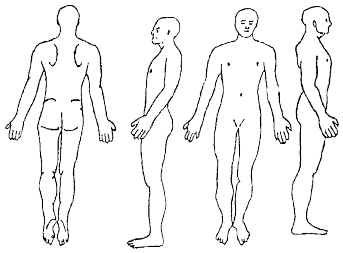
Is condition due to an accident? ☐ **$o** ☐ **Yes , If Yes :**

1. Date of accident_____ **Type of accident :** ☐ **Auto** ☐ **Work** ☐ **other**
2. Location of the accident :_____.
3. Were you knocked unconscious? □ **Yes** □ **$o** **If yes, for how long?**_____

4. In your own words, please describe accident:_____

2 - PATIENT CONDITION:

Mark the area on your body where you feel the pain:



Reason of Visit : _____
When did your Symptoms appear: _____
Please describe your condition :

What treatment have you already received for your condition?_____
_____.

I hereby certify that the enclosed information is true and answered correctly. I give my consent for examination, x-rays and treatment at the office of Dema Rehab & Injury Clinic.

Patient signature_____ Date_____
Witness signature_____ Date_____

For Insurance Verification (Office Use)

In –Network :	Co-Pay $:	Deductible $:	Has Met $:
Out of Network :	Visits limit : Coverage Amount $:	Deductible $:	Has Met $:

DEMA Rehab & Injury Clinic Inc.

Dr Ouadi Hassine DC.

PATIENT MEDICAL HISTORY

PLACE A MARK ON 'YES' OR 'NO' TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING

AIDS/HIV	□ YES □ NO	GOITER	□ YES □ NO	PNEUMONIA	□ YES □ NO
ALCOHOLISM	□ YES □ NO	GONORRHEA	□ YES □ NO	POLIO	□ YES □ NO
ALLERGY SHOTS	□ YES □ NO	GOUT	□ YES □ NO	PROSTATE PROBLEM	□ YES □ NO
ANEMIA	□ YES □ NO	HEART DISEASE	□ YES □ NO	PROSTHETICS	□ YES □ NO
ANOREXIA	□ YES □ NO	HEPATITIS	□ YES □ NO	PSYCHIATRIC CARE	□ YES □ NO
APPENDICITIS	□ YES □ NO	HERNIA	□ YES □ NO	RHEUMATOID ARTHRITIS	□ YES □ NO
ARTHRISTIS	□ YES □ NO	HERNIATED DIS	□ YES □ NO	RHEUMATOID FEVER	□ YES □ NO
ASTHMA	□ YES □ NO	HERPES	□ YES □ NO	SCARLET FEVER	□ YES □ NO
BLEEDING DISORDERS	□ YES □ NO	HIGH CHOLESTEROL	□ YES □ NO	STROKE	□ YES □ NO
BREAST LUMP	□ YES □ NO	KIDNEY DISEASE	□ YES □ NO	SUICIDE ATTEMPT	□ YES □ NO
BRONCHITIS	□ YES □ NO	LIVER DISEASE	□ YES □ NO	THYROID PROBLEMS	□ YES □ NO
BULIMIA	□ YES □ NO	MEASLES	□ YES □ NO	TONSILITIS	□ YES □ NO
		CANCER	□ YES □ NO		
CATARACTS	□ YES □ NO	MIGRANE	□ YES □ NO	TUBERCULOSIS	□ YES □ NO
MISCARRIAGE	□ YES □ NO	TUMORS GROWTHS	□ YES □ NO	MONONUCLEOSIS	□ YES □ NO
TYPHOID FEVER	□ YES □ NO	CHICKEN POX	□ YES □ NO	MULTIPLE SCLEROSIS	□ YES □ NO
DIABETES	□ YES □ NO	MUMPS	□ YES □ NO	VAGINAL INFECTIONS	□ YES □ NO
EMPHYSEMA	□ YES □ NO	OSTEOPOROSIS	□ YES □ NO	VENERAL DIASEASE	□ YES □ NO
EPILEPSY	□ YES □ NO	PACEMAKER	□ YES □ NO	WHOOPING COUGH	□ YES □ NO
FRACTURES	□ YES □ NO	PARKINSONS DISEASE	□ YES □ NO	ULCERS	□ YES □ NO
GALUCOMA	□ YES □ NO	PINCHED NERVE	□ YES □ NO		
		OTHER _____			

EXERCISE	WORK ACTIVITY	HABITS
□ NONE	□ SITTING	□ SMOKING PACKS/DAY _____
□ MODERATE	□ STANDING	□ ALCOHOL DRINKS/WEEK _____
□ DAILY	□ LIGHT LABOR	□ COFFEE/ CAFFEINE CUPS/DAY
□ HEAVY	□ HEAVY LABOR	□ HIGH STRESS LEVEL REASON

I$JURIES/SURGERIES YOU HAVE HAD:	DESCRIPTIO$	DATE
FALLS:		
HEAD I$JURIES		
BROKE$ BO$ES		
DISLOCATIO$S		
SURGERIES		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/ MINERALS

ARE YOU PREGAT □ YES □ NO DUE DATE

DEMA Rehab & Injury Clinic Inc.

Dr Ouadi Hassine DC.

REQUEST FOR RECORDS A D/OR X-RAYS

DATE _____

TO _____

ADDRESS _____

CITY _____

I HEREBY AUTHORIZE THE RELEASE OF MY X-RAYS/ RECORDS OR COPIES THERE OF AND REQUEST THAT THEY BE TRANSFERRED TO:

DEMA REHAB AND INJURY CLINIC, INC

Please fax to:

Orlando Location:

7758 Wallace Rd, Suite A&B, Orlando, Fl 32819

Tel (407)352-5882 ,Fax: (407)352-5883

Kissimmee Location:

2928 Vineland Rd, Kissimmee, Fl 34746

Tel (407)344-4242 ,Fax: (407)507-0063

NAME OF PATIENT:_____

DATE OF RECORDS:_____

PATIENT'SIGNATURE:_____

PATIENT'S BIRTHDAY: _____

PATIENT'S SOCIAL SECURITY: _____

DEMA Rehab & Injury Clinic Inc.

Dr Ouadi Hassine DC.

CAUTION ! PLEASE READ BEFORE SIGN IN. IF YOU SIGN BELOW, WE ASSUME YOU U NDERSTAND AND AGREE TO THE TERMS!

Patient's Name ___

Release of Information:

I hereby authorize this medical provider to: furnish the insurer's intermediary and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain coverage information telephonically form the insurer; to request all EOBs and non-redacted PIP payout sheets forms the insurer; MRIs, form any other medical provider or any insurer. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to third party vendors without the patient's and the provider's express written permission.
I certify that I have not been solicited or promised anything in exchanged for receiving medical care or that received an' promises or guarantees from anyone as to the result that may be obtained by any medical treatment.

Signature_____Date _____

(If patient is a minor, Signature of Parent)

Consent form for Chiropractic Adjustment and Care / Terms of Acceptance

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Chiropractic Partners offices.

I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

Signature_____Date _____

(If patient is a minor, Signature of Parent)

Hardship Agreement

To whom it may concern:

The above named clinic has agreed to accept assignment of benefits on the undersigned patient. Dema Rehab & Injury Clinic, Inc. has conditionally agreed to accept the allowable amount from the insurance company as payment in full for the undersigned patient.

It has been established that the undersigned patient is in need of corrective chiropractic treatment: however, he or she is unable to pay for these services at this time because of extreme financial hardship.

In the event that the undersigned patient's income increases, a settlement is made or other financial gains occur, and he or she is able to pay the copayment, deductable or other outstanding balances for services rendered, this agreement immediately becomes null and void.

Signature_____Date _____

(If patient is a minor, Signature of Parent)