BACK AND NECK PAIN RELIEF CENTER

DR. SYDNEY R. HOCHMAN

119 Everts Avenue • Queensbury N.Y. 12804

518 792-6262 • fax 518 792-6269

Mr., Mrs., Ms. _____ Date _____

Address_____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work# _____

Email Address _____

Social Security#_____ Age _____ Birth Date _____

Height_____Weight _____Marital Status_____Children_____

Occupation_____Employer_____

Work Address_____

Spouses Name_____ Spouses Employer _____

Nearest Relative _____ Phone # _____

How were you referred here? _____

Is this case: ❑ on the job injury ❑ auto accident ❑ other accident

Primary Care Physician _____

List Present Complaints/Concerns:

1._____ for how long _____

2._____ for how long _____

Other Doctors consulted for this condition(s):

Name _____ Diagnosis _____

Name _____ Diagnosis _____

Prior Surgeries:

Type_____ year _____ Dr. _____
Type_____ year _____ Dr. _____
Type_____ year _____ Dr. _____
Remarks_____

Serious Accidents/Falls/Fractures:

What_____year_____
What_____year_____
Rmarks_____

Other Symptoms:

❒ Headaches	❒ Pain in Hands or Arms	❒ Chest Pains
❒ Neck Pain/stiffness	❒ Numbness in Hands or Arms	❒ Heart Attack
❒ Sleeping Problems	❒ Pain in Legs or Feet	❒ High Blood Pressure
❒ Low Back Pain	❒ Numbness in Legs or Feet	❒ Stroke
O Nervousness	❒ Fatigue	❒ Cancer
❒ Depression	❒ Painful Urination	❒ Asthma
❒ Lights Bother Eyes	❒ Diabetes	❒ Allergies
❒ Dizziness	❒ Loss of Memory	❒ Diarrhea
❒ Pain Between Shoulders	❒ Shoulder Pain	❒ Constipation
❒ Sinus	❒ Stomach Upset	❒ Loss of Smell or Taste
❒ Joint Swelling	❒ Shortness of Breath	❒ Menstrual Cramps
❒ Fever	❒ Loss of Balance	❒ Weight Loss

❒ other symptoms:_____

Significant medical history or family history - please explain:_____

_____

_____

❒ Smoker_____/day ❒ Alcohol - how much/often?_____

Medications/Vitamins:

What _____ dosage _____ Dr. _____
What _____ dosage _____ Dr._____
What _____ dosage _____ Dr. _____
What _____ dosage _____ Dr. _____
Others/remarks_____

I hereby assign payment directly to Dr. Sydney Hochman for professional services rendered and I shall be personally responsible for any unpaid balance to Dr. Hochman.

Patient/Insured Signature_____ **Date** _____

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119 EVERTS AVENUE • QUEENSBURY, NY 12804
TELEPHONE: (518) 792-6262 • FAX: (518)792-6269

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.

A Back and Neck Pain Relief Center
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Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____
Patient's Name (Print) Patient's Signature

_____ _____
Date Relationship or authority if not signed By patient

_____
Witness