

**PATIENT QUESTIONNAIRE  
Clinic**

**Bauman Chiropractic**

3613 North Highway 231  
Panama City, Fl. 32404

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
SS# \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PHONE: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ (CELL) \_\_\_\_\_  
PHYSICAL ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MARITAL STATUS: M S D W Sep. SPOUSE NAME: \_\_\_\_\_  
(circle one)

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_ PHONE: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

WHO IS RESPONSIBLE FOR YOUR BILL?  SELF  SPOUSE  PARENT/GUARDIAN  
 EMPLOYER  OTHER: \_\_\_\_\_

MEDICAL INSURANCE CARRIER \_\_\_\_\_ ID# \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

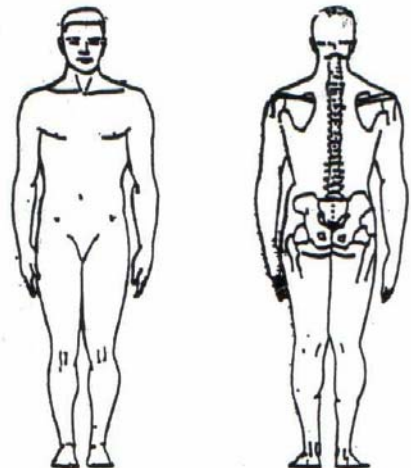
IS THIS INJURY DUE TO AN AUTOMOBILE ACCIDENT?  YES  NO  
DATE OF ACCIDENT \_\_\_\_\_ STATE ACCIDENT OCCURRED \_\_\_\_\_  
WERE YOU AT FAULT? \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_  
AUTOMOBILE INSURANCE CARRIER \_\_\_\_\_  
PHONE # \_\_\_\_\_ CLAIM # \_\_\_\_\_

IS THIS A WORK RELATED INJURY?  YES  NO DATE OF ACCIDENT \_\_\_\_\_  
WORK COMP. INSURANCE CARRIER \_\_\_\_\_  
CLAIM # \_\_\_\_\_ ADJUSTER \_\_\_\_\_  
PHONE # \_\_\_\_\_

DO YOU HAVE A PRESCRIPTION?  CHIROPRACTIC  PHYSICAL THERAPY  
(not required)

PLEASE DESCRIBE YOUR PRIMARY COMPLAINT

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM.  
ALSO DESCRIBE THE FREQUENCY OF YOUR PAIN AND ANY ACTIVITY  
THAT INCREASES OR AGGRAVATES YOUR PAIN.

**PATIENT QUESTIONNAIRE – PAGE 2  
Clinic**

**Bauman Chiropractic**

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DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Please list the medications that you are currently taking:

\_\_\_\_\_ Nerve Pills: \_\_\_\_\_

\_\_\_\_\_ Pain Killers: \_\_\_\_\_

\_\_\_\_\_ Muscle Relaxers: \_\_\_\_\_

\_\_\_\_\_ “PEP” Pills: \_\_\_\_\_

\_\_\_\_\_ Tranquilizers: \_\_\_\_\_

\_\_\_\_\_ Insulin: \_\_\_\_\_

\_\_\_\_\_ Birth Control Pills: \_\_\_\_\_

\_\_\_\_\_ Diet Pills: \_\_\_\_\_

\_\_\_\_\_ Other: (please list) \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

ADDRESS : \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE LAST SEEN: \_\_\_\_\_

**FINANCIAL ARRANGEMENT:**

**Fees are payable at the time services are rendered, unless prior arrangements have been made.**

**ORIGINAL RADIOGRAPHS (X-RAYS) REMAIN PROPERTY OF THIS CLINIC**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand and agree that health and accident 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 me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Bauman Chiropractic Clinic of Northwest Florida

3613 North Highway 231, Panama City Fl. 32404

Phone: 850-785-8311 Fax: 850-872-9892

## MEDICAL RECORDS REQUEST

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE OF LOSS: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_

FROM: \_\_\_\_\_

TO: BAUMAN CHIROPRACTIC CLINIC

3613 Hwy 231 North

PANAMA CITY, FL 32404

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ف Date Requested \_\_\_\_\_

ف Medical Records    ف Progress Notes    ف Any Radiographs or other reports    ف Other: \_\_\_\_\_

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED \_\_\_\_\_

**THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPAA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(10) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR THE LEGAL REPRESENTATIVES.**

\_\_\_\_\_  
PATIENT OR GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESSED BY

I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA P.A. TO RECEIVE A COPY OF MY PATIENT RECORDS OR X-RAYS CONTAINING PROTECTED HEALTH INFORMATION.

DATE FAXED: \_\_\_\_\_ (850-872-9892)

WILL PICK UP: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE MAILED: \_\_\_\_\_

I HEREBY ACKNOWLEDGE RECEIPT OF THESE RECORDS AND/OR X-RAYS. IN CONSIDERATION OF THE FOREGOING, I HEREBY RELEASE AND FOREVER DISCHARGE THE AFORESAID DOCTOR OF CHIROPRACTIC FROM ANY AND ALL RESPONSIBILITY OR LIABILITY OF ANY KIND, NATURE, OR CHARACTER WHATSOEVER ARISING FROM SAID TREATMENT.

# BAUMAN CHIROPRACTIC CLINIC OF NW FL.

3613 N. Hwy 231, Panama City Fl. 32404

Ph: 850-785-8311 Fax: 850-872-9892

## MEDICAL RECORDS RELEASE

### RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION

**I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA P.A. TO RELEASE A COPY OF MY PATIENT RECORDS, X-RAYS AND ACCOUNT RECORDS CONTAINING PROTECTED HEALTH INFORMATION TO:** \_\_\_\_\_

THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPAA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(10) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR THE IR LEGAL REPRESENTATIVES.

I UNDERSTAND THAT THIS INFORMATION MAY INCLUDE INFORMATION RELATING TO: ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION; TREATMENT FOR DRUG OR ALCOHOL ABUSE, MENTAL OR BEHAVIORAL HEALTH OR PSYCHIATRIC CARE, EXCLUDING PSYCHOTHERAPY NOTES. ANY RELEASE OF SUBSTANCE INFORMATION MUST BE PURSUANT TO 42 CFR. THERE ARE OTHER SPECIAL RESTRICTIONS WHICH APPLY TO THE RELEASE OF INFORMATION REGARDING HIV, ABUSE REPORTS, ETC...

\_\_\_\_\_  
**PATIENT OR GUARDIAN SIGNATURE      DATE SIGNED      WITNESSED BY**

UNLESS OTHERWISE REVOKED, THE AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: \_\_\_\_\_

### SPECIFIC DESCRIPTION OF INFORMATION REQUESTED AND DISCLOSED

I HEREBY ACKNOWLEDGE RECEIPT OF THESE RECORDS AND/OR X-RAYS. IN CONSIDERATION OF THE FOREGOING, I HEREBY RELEASE ANK FOREVER DISCHARGE THE AFORESAID DOCTOR OF CHIROPRACTIC FROM ANY AND ALL RESPONSIBILITY OR LIABLITY OF ANY KIND, NATURE OR CHARACTER WHATSOEVER ARISING FROM SAID TREATMENT.  
TAX ID 80-000-9303

\_\_\_\_\_  
**SIGNATURE / RECEIPT OF RECORDS**

\_\_\_\_\_  
**DATE**