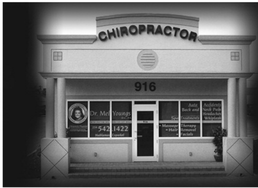
ONE GREAT PLACE TO GET WELL



Dr. Mel Youngs, D.C.
Dr. Caren Polk D.C.
(239) 542-1422 FAX: (239) 542-9688 www.dryoungs.com

Today's Date ________/________/__________

TELL US ABOUT YOURSELF

Patient Name: ______________________ (Last) ______________________ (First) ____ (MI) Nickname: ____________________ ❍ Male ❍ Female

Birthdate: ____/____/____ Age:___ SS#: ________________ Primary Phone#: ________________ Alt. Phone#: ________________

Mailing Address: ______________________ (City) _____ (State) _________ (Zip) Email Address: ______________________

Employer: ______________________ Occupation: ______________________

Employer Address: ______________________ (City) _____ (State) _________ (Zip) Referred By: ______________________

Status: ❍ Minor ❍ Single ❍ Married ❍ Divorced ❍ Separated ❍ Widowed ❍ Significant Other

Spouse's Name: ______________________ Do you have children? ❍ Yes ❍ No How many? __________

ACCOUNT INFORMATION

❍ SAME AS ABOVE Name of Person Ultimately Responsible for Account ______________________

Billing Address: ______________________ (City) _____ (State) _________ (Zip) Email Address: ______________________

SS# ____________________ Drivers License #: ____________________ Payment Method: ❍ Cash ❍ Check

Credit Card ____________________ Name on Credit Card ______________________ Exp. Date ___/___

IN THE EVENT OF AN EMERGENCY

Name of whom we should contact: ______________________ Relationship: ______________________

Primary Phone #: ____________________ Medical Doctor: ____________________ Phone #: ____________________

IRREVOCABLE AGREEMENT FOR PAYMENT

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 or treatment that any fees for professional services rendered to me will be immediately due and payable. I understand and agree that if charges are to be filed with an insurance carrier that health and accident insurance carrier and myself. Furthermore, I understand that DR. MEL YOUNGS, D.C., P.A. will prepare any necessary forms to assist me in making collection from my insurance carrier and that any amount authorized will be paid directly to DR. MEL YOUNGS, D.C., P.A. and will be credited to my account upon receipt. I understand that DR. MEL YOUNGS, D.C., P.A. is acting solely as an agent for me in filing to my insurance carrier for benefits assigned to me and authorize release of any information required to support my claim. However, DR. MEL YOUNGS, D.C., P.A. can assume no responsibility for guaranteeing payment of covered services. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier as well as any attorney fees and costs incurred to collect for these services.

__________ Initials

CONSENT FOR TREATMENT

I understand that if I am accepted as a patient of DR. MEL YOUNGS, D.C., P.A., I authorize DR. MEL YOUNGS, D.C., P.A. and her staff to proceed with any treatment that may be medically necessary. Furthermore, any risk associated with Chiropractic treatment will be explained to me upon my request.

__________ Initials

If under 18: I hereby authorize Dr. Mel Youngs, D.C., P.A. to administer treatment without my being present at the time of treatment.

__________ Initials

ASSIGNMENT OF BENEFITS

I hereby authorize (Name of Insurance Carrier)______________________to pay and mail directly to DR. MEL YOUNGS, D.C., P.A. the benefits otherwise payable to me or for my dependent for their services, but not to exceed the charges for those services. I hereby irrevocably assign to DR. MEL YOUNGS, D.C., P.A., any benefits under any policy medical of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any services and charges provided DR. MEL YOUNGS, D.C., P.A."

__________ Initials

Check out our monthly spa specials at Dryoungs.com ~ Email your paperwork to office@dryoungs.com

REASON FOR TODAY'S VISIT

❍ Emergency ❍ New Injury ❍ Old Injury ❍ Chronic Pain ❍ Wellness Are you in pain: ❍ Yes ❍ No

Rate your pain with the following scale: mild 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ❍ Work ❍ Sports/play ❍ Auto Accident

When did your condition/accident occur: __/___/___ Please explain what happened: ____________________

____

Is your condition getting worse? ❍ Yes ❍ No ❍ Constant ❍ Comes and goes Has this ever happened before? ❍ Yes ❍ No

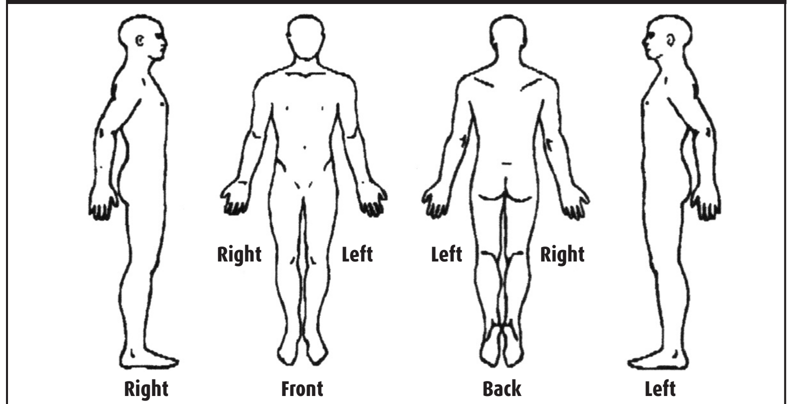
Have you ever been treated by a Medical Physician for this condition? ❍ Yes ❍ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke
Y N Artificial Valves
Y N Shingles
Y N Emphysema / Asthma
Y N Ulcers/ Colitis
Y N Cancer
Y N Chemotherapy
Y N Hepatitis
Y N High/Low Blood Pressure
Y N Alcohol / Drug Abuse
Y N Psychiatric Problems
Y N Fainting/Seizures/ Epilepsy

Y N Tuberculosis
Y N Venereal Disease
Y N Rheumatic Fever
Y N Glaucoma
Y N Frequent Neck Pain
Y N Frequent Low Back Pain
Y N Heart Murmur
Y N Arthritis
Y N Rheumatic Fever
Y N Sinus Problems
Y N Congenital Heart Defect

PLEASE CIRCLE ALL THE AFFECTED AREAS



Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

____

____

List any past accidents with dates: ____________________

Please list anything that you may be allergic to: ____________________

Do you take any Supplements or Vitamins? ❍ Yes ❍ No Do you exercise? ❍ Yes ❍ No ______hours per week

Do you smoke? ❍ Yes ❍ No How much? __________ How long? ___________

For women: Are you taking Birth Control? ❍ Yes ❍ No Are you Nursing? ❍ Yes ❍ No Are you pregnant? ❍ Yes ❍ No

We invite you to discuss with us any questions regarding our services.
The best health services are based on a friendly, mutual understanding between provider and patient.

OUR POLICY

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. **I understand that it is my responsibility to inform the office of any changes to my account.**

I understand that Dr. Mel Youngs, D.C., P.A. has a No-Show Policy for Massage Therapy. The office requires a 24 hour notice prior to cancelling an appointment. **If there is not a 24 hr notice given I will be charged a $25 cancellation fee. I understand this charge is my responsibility and will not be passed on to my insurance company.**

Signature ______________________________ Date: ___/___/___