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CONFIDENTIAL

PATIENT CASE HISTORY

Name _____ DOB _____

Home _____ Age _____

Address _____ # of children _____

_____ Marital Status S M D W

Work # _____ Spouse's Name _____

Home # _____ Spouse's Phone _____

E-mail _____

Employer _____ Referred by: _____

SS# _____

HEALTH INFORMATION

What is your major complaint? _____

Other complaints: _____

How long have you had this condition (approximate date)? _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ❑ YES ❑ NO ❑ CONSTANT ❑ COME & GOES

Is this condition interfering with your: ❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER _____

How long has it been since you really felt good? _____

Other doctors who treated this condition: _____

List surgical operations and years: _____

_____

Drugs you now take:
❑ NERVE PILLS ❑ PAIN KILLERS ❑ MUSCLE RELAXERS
❑ "PEP" PILLS ❑ TRANQUILIZERS ❑ INSULIN
❑ BIRTH CONTROL ❑ OTHER _____

Age of mattress _____ ❑ COMFORTABLE ❑ UNCOMFORTABLE

Are you wearing: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

Have you been in an auto accident? ❑ PAST YEAR ❑ PAST 5 YEARS ❑ OVER 5 YEARS ❑ NEVER

Describe _____

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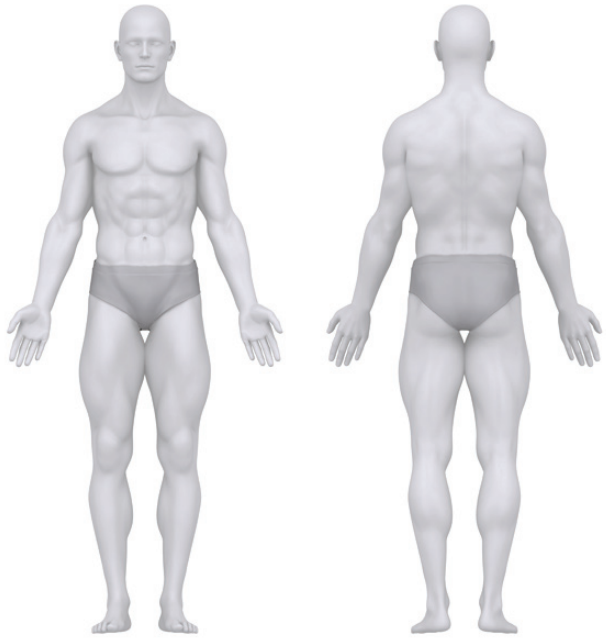
PATIENT CASE HISTORY

Date of Last Physical Examination _____



Have you ever suffered from?

1.	Dizziness	❑ YES	❑ NO
2.	Backaches	❑ YES	❑ NO
3.	Heart trouble	❑ YES	❑ NO
4.	Diabetes	❑ YES	❑ NO
5.	Arthritis	❑ YES	❑ NO
6.	Headaches	❑ YES	❑ NO
7.	Asthma	❑ YES	❑ NO
8.	Neuritis	❑ YES	❑ NO
9.	Digestive Disorders	❑ YES	❑ NO
10.	Nervousness	❑ YES	❑ NO
11.	Sinus trouble	❑ YES	❑ NO
12.	Neck Pain	❑ YES	❑ NO

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ❑ YES ❑ NO

Do you have health insurance? ❑ YES ❑ NO

Name of Company _____ Policy # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Medical 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 Medical Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

Patient's Signature: _____ Date _____

Guardian or Spouse Signature: _____ SS# _____

Doctor's Signature: _____ Date _____

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ASSIGNMENT/DIRECT PAYMENT TO DOCTOR PRIVATE/GROUP ACCIDENT AND HEALTH INSURANCE

PATIENT: _____

EMPLOYER: _____

GROUP NO: _____

SSN/ID: _____

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

120 East 42nd Street, 5th Floor
New York, NY 10017
Phone 212.370.5551

61 Broadway, Suite 900
New York, NY 10006
Phone 212.248.0077

100 William Street, Suite 1215
New York, NY 10038
Phone 212.509.3333

If policy provisions prohibit direct payment to physician, I hereby also instruct and direct you to make out the check to me and mail to one of the addresses above. Payment is for the professional or medical expense benefits allowable, and otherwise payable, to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Agreement of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

Date Signature of Policy Holder

_____

Witness

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PATIENT'S PREGNANCY EVALUATION FORM

Dear Patient,

In order for us to fully evaluate you we are required to take x-rays of some part(s) of your body. It has been predicted that an unborn child in its first trimester would be more sensitive to radiation than an adult. In order to insure that accidentally, knowingly or otherwise, no Fetus (unborn child) be exposed to radiation from x-ray machines, we ask you to provide us with the following information. We thank you for the information and this information is strictly confidential and is solely used for the purpose it is intended.

DATE: _____

NAME: _____

DATE OF THE ONSET OF LAST MENTRUAL PERIOD: _____

IS THERE ANY CHANCE THAT YOU MAY BE PREGNANT? ❑ YES ❑ NO

To the best of my knowledge, I am not pregnant and by providing this application for Physician/Technologist has informed me of the effects of Radiation to the Unborn baby and me by signing below have consented to taking the x-rays of my body parts for further studies.

SIGNATURE: _____

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AXON HEALTH ASSOCIATES
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Axon Health Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Axon Health Associates notice of privacy practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Axon Health Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Axon Health Associates, 120 East 42nd Street, NY, NY 10017.

With this consent Axon Health Associates may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent Axon Health Associates may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With the consent of Axon Health Associates may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Axon Health Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Axon Health Associates to use and disclose of mu PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Axon Health Associates may decline to provide treatment to me.

Patients Name _____ Date _____

Signature of patient or legal Guardian _____

Print Name of Patient or Legal Guardian _____