DR. MARK KEMENOSH
RELEASE PAIN, REACH POTENTIAL

Date _____

Name _____
Last Name First Name M.I.

Address _____ City _____ State _____ Zip _____

E-mail _____ Birthdate _____ Age _____

Sex ☐M ☐F Occupation _____ Employer/School _____

Employer/School Address _____ Employer/School Phone (_____) _____

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____ years

Spouse's Name _____ Birthdate _____ Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Cell Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐Yes ☐No

Date _____

Type ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?
☐Auto Ins. ☐Employer ☐Worker Comp. ☐Other

Attorney Name (if applicable)
_____

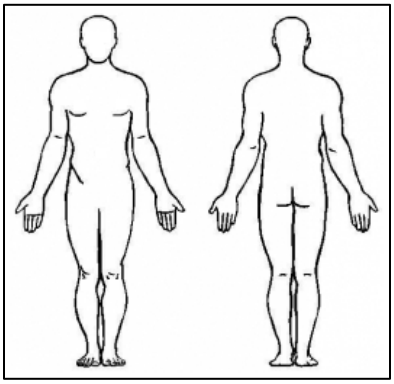
PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). _____

Type of pain ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? _____ Is it constant or come and go? _____

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy

☐Chiropractic Services ☐None ☐Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical Exam:_____ Spinal X-ray: _____ Blood Test:_____

Spinal Exam:_____ Chest X-ray: _____ Urine Test: _____

Dental X-ray: _____ MRI, CT-Scan, Bone Scan: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□Yes □No	Chicken Pox	□Yes □No	Liver Disease	□Yes □No	Psychiatric Care	□Yes □No
Alcoholism	□Yes □No	Diabetes	□Yes □No	Measles	□Yes □No	Rheumatoid Arthritis	□Yes □No
Allergy Shots	□Yes □No	Emphysema	□Yes □No	Migraines	□Yes □No		
Anemia	□Yes □No	Epilepsy	□Yes □No	Miscarriage	□Yes □No	Rheumatic Fever	□Yes □No
Anorexia	□Yes □No	Fractures	□Yes □No	Mononucleosis	□Yes □No	Scarlet Fever	□Yes □No
Appendicitis	□Yes □No	Glaucoma	□Yes □No	Multiple Sclerosis	□Yes □No	Stroke	□Yes □No
Arthritis	□Yes □No	Goiter	□Yes □No			Suicide Attempt	□Yes □No
Asthma	□Yes □No	Gonorrhea	□Yes □No	Mumps	□Yes □No	Thyroid Problems	□Yes □No
Bleeding Disorders	□Yes □No	Gout	□Yes □No	Osteoporosis	□Yes □No	Tonsillitis	□Yes □No
		Heart Disease	□Yes □No	Pacemaker	□Yes □No	Tuberculosis	□Yes □No
Breast Lump	□Yes □No	Hepatitis	□Yes □No	Parkinson's Disease	□Yes □No	Tumors, Growths	□Yes □No
Bronchitis	□Yes □No	Hernia	□Yes □No			Typhoid Fever	□Yes □No
Bulimia	□Yes □No	Herniated Disk	□Yes □No	Pinched Nerve	□Yes □No	Ulcers	□Yes □No
Cancer	□Yes □No	Herpes	□Yes □No	Pneumonia	□Yes □No	Vaginal Infections	□Yes □No
Cataracts	□Yes □No	High Cholesterol	□Yes □No	Polio	□Yes □No	Venereal Disease	□Yes □No
Chemical Dependency	□Yes □No			Prostate Problem	□Yes □No	Whooping Cough	□Yes □No
		Kidney Disease	□Yes □No	Prosthesis	□Yes □No	Other	□Yes □No

EXERCISE

□None
□Moderate
□Daily
□Heavy

WORK ACTIVITY

□Sitting
□Standing
□Light labor
□Heavy Labor

HABITS

□Smoking
□Alcohol
□Coffee/Caffeine Drinks
□High stress level

Packs/day_____
Drinks/week_____
Cups/day_____
Reason_____

Are you pregnant? ☐Yes ☐No Due date: _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head injuries		
Broken bones		
Dislocations		
Surgeries		

GLEN OAKS HEALTH AND SPINE CENTER

Name:

Date of Birth:

Blood Pressure:

Height:

Weight:

Please list your active medications and dosage:

Reactions/allergies to prescription drugs? Please list:

Please list any vitamins, herbs, or minerals you take:

Tobacco use: YES or NO

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZATION FORM

Mark Kemenosh

Financial Responsibility

I have requested professional services from **Glen Oaks Health & Spine Center / Mark Kemenosh** on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled, to **Glen Oaks Health & Spine Center / Mark Kemenosh** I certify that the health insurance information that I provided to **Glen Oaks Health & Spine Center / Mark Kemenosh** is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize **Glen Oaks Health & Spine Center / Mark Kemenosh / CB&C** to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to **Glen Oaks Health & Spine Center / Mark Kemenosh** in good faith. I also hereby instruct my benefit plan (or its administrator) to pay **Glen Oaks Health & Spine Center / Mark Kemenosh** directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to **Glen Oaks Health & Spine Center / Mark Kemenosh**, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and **Glen Oaks Health & Spine Center / Mark Kemenosh** upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to **Glen Oaks Health & Spine Center / Mark Kemenosh**.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from **Glen Oaks Health & Spine Center / Mark Kemenosh** are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize **Glen Oaks Health & Spine Center / Mark Kemenosh / CB&C** to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to **Glen Oaks Health & Spine Center / Mark Kemenosh / CB&C** to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance police and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from **Glen Oaks Health & Spine Center / Mark Kemenosh** and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient – Print here and sign above Date

_____ _____

Policyholder/Insured Date

Date:_____

Dear Insurance Carrier,

I understand that you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient: _____ SS# _____ DOB: _____

Insured name: _____ Policy ID# _____ Relation to insured: _____

PLEASE SELECT FROM SECTIONS BELOW & CHECK ONLY *ONE* STATEMENT THAT APPLIES TO YOUR INSURANCE COVERAGE – YOU MUCH SIGN THAT SECTION:

Self:

_____ I am the patient AND the insured AND I have no other insurance coverage.

_____ _____

Authorized Signature Date

Spouse/Partner:

_____ I am the patient, BUT the insured is my spouse/partner _____. I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am employed at _____ but have no coverage through that employer.

_____ I am the patient & have my own coverage – the following is my coverage information:

Primary Ins: _____ Insured Name: _____ Insured DOB: _____

Secondary Ins: _____ Insured Name: _____ Insured DOB: _____

_____ _____

Authorized Signature Date

Dependent Child (in school): (covered under parent's policy)

_____ I am a student & have 1 policy. Attached is my current school schedule.

Primary Ins: _____ Insured Name: _____ Insured DOB: _____

_____ I am a student & have 2 polices. Attached is my current school schedule.

Primary Ins: _____ Insured Name: _____ Insured DOB: _____

Secondary Ins: _____ Insured Name: _____ Insured DOB: _____

_____ _____

Authorized Signature Date

Dependent Child Under (not in school): (covered under parent's policy)

_____ I am a dependent on the policy and only covered under this policy.

Primary Ins: _____ Insured Name: _____ Insured DOB: _____

_____ I am a dependent and covered under two policies.

Primary Ins: _____ Insured Name: _____ Insured DOB: _____

Secondary Ins: _____ Insured Name: _____ Insured DOB: _____

_____ _____

Authorized Signature Date

DR.MARK KEMENOSH
RELEASE PAIN, REACH POTENTIAL

WWW.GLENOAKSHEALTHANDSPINE.COM

Three Jefferson Drive
Laurel Springs, New Jersey 08021
Phone: (856) 228-3100
Fax: (856) 228-3108

Date: _____

NON-AUTO

Dear Insurance Carrier:

I, _____, am currently receiving chiropractic care at **MARK KEMENOSH, D.C.** this facility. Please know that this care is *not related* to any auto accident, workers' compensation injury, or any other type of injury, which would render a third party liable for these bills.

My complaint is _____ as a result of _____.
My first date of treatment is _____.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

_____
Print Name

_____ _____
Signature Date