DAVID P. SNIEZEK, DC, MD MBA, FAAIM, FAAMA

Patient Information Sheet

Personal Information

Name:________________________________ Date of Birth: _______________ Age: Sex: _ Visit Date: _____________

Mailing Address:____ Social Security #: _________________________

____ Ethnicity: _________________________

City State Zip Code Work #: _________________________

Home Telephone #: _____________________________________ Cell #: _________________________

E-mail Address: _____________________________________ Primary Language: _________________________

Contact Preference: Home Work Cell E-mail Do you have a living will? Yes No

How did you hear about us? ____

Referring Physician Name, Address, & Telephone #: ____

____

Primary Care Physician Name, Address, & Telephone #: ____

____

Name of Employer: ____ (Self Employed: Yes No)

Employer's Address & Telephone #: ____

Emergency Contact: ____ Emergency Telephone #: ____________________

Insurance Information

Primary Insurance

Name of Person Insured: ______________________________________ Insured's Date of Birth: ____________________

Insured Social Security #: ______________________________________ Employer's Name: ____________________

Name of Insurance Company & Address: ____

Telephone #: _________________________ Policy/ID #: _________________________ Group/Account #: ____________________

Secondary Insurance

Name of Person Insured: ______________________________________ Insured's Date of Birth: ____________________

Insured Social Security #: ______________________________________ Employer's Name: ____________________

Name of Insurance Company & Address: ____

Telephone #: _________________________ Policy/ID #: _________________________ Group/Account #: ____________________

Workers Compensation Information --- **Is this Workers Compensation? Yes No**

Date of Injury: ____________________ Claim #: __________________________________

Workers Compensation Name, Address, & Telephone #: ____

____

Auto Accident Information --- **Is this from an Auto Accident? Yes No**

Date of Injury: ____________________ Claim #: __________________________________

Auto Insurance company Name, Address, & Telephone #: ____

____

Release of Information

I hereby authorize any treatment deemed necessary by Dr. David Sniezek. I also authorize the release of any information necessary to process my claim.

____ _______________

Signature of Insured / Authorized person Date

Assignment of Benefits

I authorize payment of benefits to Dr. David Sniezek for ALL services rendered. I understand that I may be responsible for any balance NOT covered by my insurance company.

____ _______________

Signature of Insured / Authorized person Date

Account Balance Policy

If I have an outstanding balance of more than $100.00 on my account at the time of my appointment, I agree to pay at least $25 per week towards my account balance in addition to other fees I have already accepted, until the balance is below $100.00. If I am unable to make this payment, I understand my appointment may be cancelled or rescheduled until I am able to do so.

____ _______________

Signature of Insured / Authorized person Date

DAVID P. SNIEZEK, DC, MD, MBA, FAAIM, FAAMA

Patient History

Please fill out this form to the best of your knowledge

Patient Information

Patient Name: ______________________________ Age:__________ Date:____________________

Date of Birth: ______________ Sex: ________ Height: __________ Weight: __________ Right/Left Handed:____________

Primary Care Physician: ______________________________ Phone #: ____________________

Referring Physician: ______________________________ Phone #: ____________________

Reason for Evaluation (please describe in detail your illness/injury): ______________________________

____

____

____

____

____

____

____

Date when illness/injury began: ____________________

Review of Systems

Please circle or check all that apply

Heart:

Chest Pain	Irregular Heart Rate	Phlebitis	Bypass Surgery	Coronary Artery Disease
Palpitations	Valve Replacement	Cellulitis	Catheterization	Other: ______________
Heart Failure	Hypertension	Lymphedema	Angioplasty	______________
Pacemaker	Hypercholesterol	Stent Placement		

Lungs:

Emphysema	Shortness of Breath	Pneumonia	Asthma	Pulmonary Embolism

Other: ______________________________

Gastrointestinal:

Reflux Disease	Hiatal Hernia	Hemorrhoids	Abdominal Aortic Aneurysm	
Gallstones	Gallbladder Removal	Appendectomy	Colon Resection	Hepatitis
Bowel Incontinence	Other: ______________________________			

Genitourinary:

Enlarged Prostate	Indwelling Catheter	Kidney Stones	Frequent Urinary Tract Infections
Hysterectomy	Bladder Incontinence	Prostate Surgery	Other: ______________________

Musculoskeletal:

Fractures	Osteoarthritis	Neck Pain	Rheumatoid Arthritis	Osteoporosis
Low Back Pain	Scoliosis	Disc Disease	Other: ______________________	

Endocrine:

Diabetes	Hypothyroid	Other: ______________

Mental Health:

Depression	Anxiety	Bipolar Disorder	Panic Attacks	Schizophrenia

Other: ______________________________

Cancer:

Location: ____

Surgery: ____

Chemotherapy: Yes No Duration: ______________________

Radiation: Yes No Duration: ______________________

Do you need **HELP** with any of the following? (please circle **ALL** that apply):

Grooming	Getting in/out of bed	Feeding
Upper body dressing	Getting in/out of chairs	Toileting
Lower body dressing	Getting in/out of tub or shower	Bathing

Do you have any of the following symptoms? (please circle **ALL** that apply):

Weight Loss	Chest Pain	Balance	Fever	Swelling
Blurred Vision	Chills	Numbness/Tingling	Headaches	Nausea
Incontinence	Weakness	Vomiting	Insomnia	Memory
Diarrhea	Sexual Function	Tremors/Shaking	Constipation	Walking
Muscle Spasms	Dizziness	Shortness of Breath	Swallowing	

Medication (please list **ALL** medication and directions)

____

____

____

____

____

____

____

Pharmacy Name, Address, & Telephone #: ____

____

Medication Allergies: ____

____

Other Allergies: ____

****Our medication refill number is (202) 296-3555. Please note there is a 5 business day notice for all refill requests.****

Past Medical History (Please list any surgery or test)

Surgery (type and date): ____

____

____

Test (MRI, CT scan, EMG, etc…….) (type and date): ____

____

____

____

____

____

Social History

Work

Occupation: ______________________________

Date last worked: ______________________________

Living accommodations (house, apartment, nursing home, etc…….): ______________________________

Patient lives with: ______________________________

Do you require assistive devices? Yes No

Type (circle **ALL** that apply): Cane Crutches Walker Wheelchair Braces Splints

Do you smoke current? Yes No

Packs per day: __________

Did you smoke previously? Yes No

Do you drink alcohol? Yes No

How much per week: __________

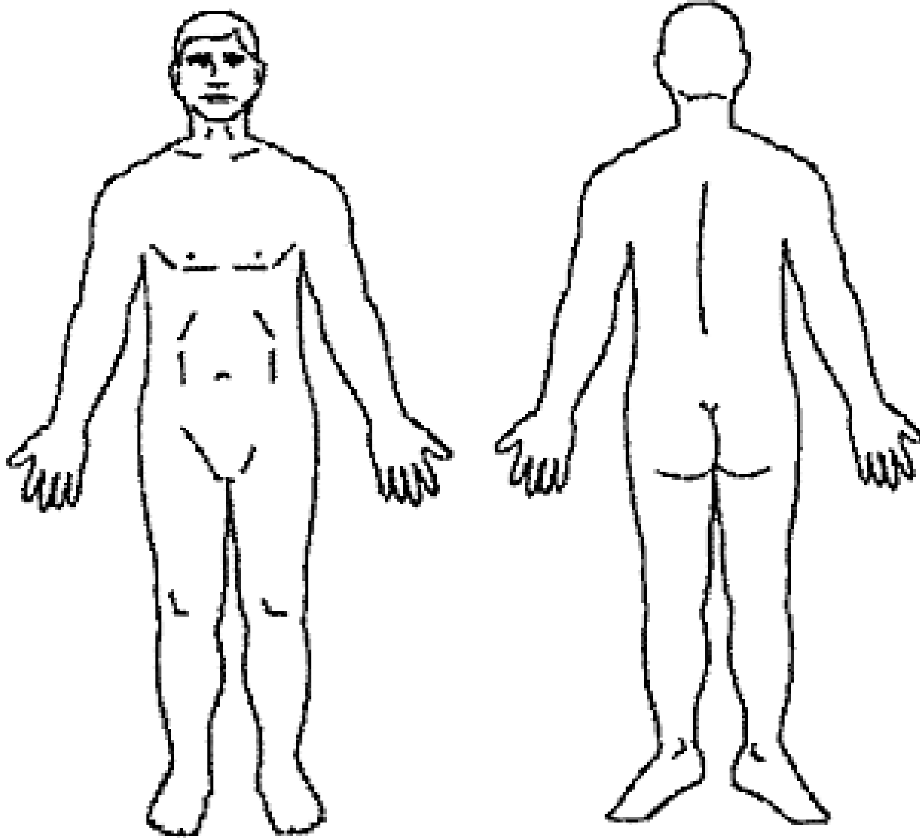
Do you use recreational drugs? Yes No

Please mark on the diagram below where your pain occurs

Dull Pain – “+”
Numbness – “N”

Burning Pain – “B”
Pins/Needles – “X”

Sharp/Stabbing Pain – “S”
Other/Describe – “/”



What is the current level of your pain? Mark on line with an X

None 0 1 2 3 4 5 6 7 8 9 10 Severe

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Cancellation and No Show Policy

908 New Hampshire Ave., NW Ste 500
Washington, DC 20037
Phone # 202-296-3555
Fax # 202-403-0578

1749 Old Meadow Rd, Ste 200
McLean, VA 22102
Phone # 703-506-8471
Fax # 202-403-0578

Attendance in our Pain Management and Physical Therapy program is required in order for your recovery and rehabilitation to be effective. We take great pride in returning patients back to their pre-injury lifestyles quickly and effectively. Our success has been directly linked to our patient's compliance with attendance, therefore we have developed this policy:

- If a patient cancels/no shows (3) times during the treatment process, he/she may be discharged/released from care.
- The rescheduling of cancelled appointments are NOT included in the (3) times
- If a patient is under Worker's Compensation, the case manager will be notified for each cancel.
- No shows can be assessed the following charge:
  - No show for schedule procedure $50.00
  - No show for established patient $35.00
  - No show for new patient $50.00
- Patients that arrive more than 15 minutes past their scheduled visit WITHOUT calling to notify may be assessed a $25 no show charge, and may need to be re-scheduled.

Please be prompt for all scheduled visits. We pride ourselves on the effectiveness of one-on-one care. Patients that arrive late for scheduled visits affect the one-on-one care of themselves and others.

Thank You!

Patient Name (please print)	Patient Signature	Date
Employee Name (please print)	Employee Signature	Date

DAVID P. SNIEZEK, DC, MD, MBA, FAAIM, FAAMA

Acknowledgement of Receipt of Notice of Privacy Practices

908 New Hampshire Ave., NW, Ste 500
Washington, DC 20037
Phone # 202-296-3555
Fax # 202-403-0578

1749 Old Meadow Rd, Ste 200
McLean, VA 22102
Phone # 703-506-8471
Fax # 202-403-0578

Please print, sign, and date your name that Notice of Privacy Practices form was received.

____
Patient or Legal Representative, Name (please print)

____
Patient or Legal Representative, Signature

____
Date

*****PHOTOS MAY BE TAKEN FOR INTERNAL USE*****

Acknowledgement <u>NOT</u> obtained because:

__ Patient of Legal Representative declined Notice of Patient Privacy Practices
__ Patient incompetent
__ Patient unable to sign
__ Other (describe briefly)

____
____

____
Employee Name (please print)

____
Employee Signature

____
Date