

WELCOME

NILE R. LESTRANGE, M.D.
1600 South Federal Highway, Tenth Floor
Pompano Beach, FL 33062
Telephone: (954) 788-9000 Fax: (954) 788-9307

TODAY'S DATE: _____

PATIENT INFORMATION All information is kept strictly confidential.

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE #: _____ CELL PHONE #: _____ WORK PHONE #: _____

SOCIAL SECURITY #: _____ - _____ - _____ DATE OF BIRTH: _____ AGE: _____

SEX: (circle) **MALE** **FEMALE**

MARITAL STATUS: (circle) **MARRIED** **DIVORCED** **SINGLE** **WIDOWED** **MINOR**

EMPLOYER/SCHOOL: _____ OCCUPATION/LEVEL: _____

EMERGENCY CONTACT: _____
(Name) (Phone) (Relationship)

Whom may we thank for referring you to our office? _____

ACCOUNT COVERAGE AND PAYMENT Complete one section only.

INSURANCE COVERAGE:

Primary Insurance Company: _____ ID #: _____ Group #: _____

Is policy in your name? **YES** **NO** If NO, Subscriber's Name: _____ Date of Birth: _____

Secondary Insurance Company: _____ ID #: _____ Group #: _____

MOTOR VEHICLE ACCIDENT/SLIP & FALL:

Insurance Carrier: _____ Policy #: _____ Phone #: _____

Name of Insured: _____

Attorney Name: _____ Phone #: _____ Fax #: _____

Date of Accident: _____ Claim #: _____

WORKERS' COMPENSATION COVERAGE:

Insurance Carrier: _____ ID #: _____ Group #: _____

Adjuster Name: _____ Adjuster Phone #: _____ Ext: _____

Date of Accident: _____ Claim #: _____

FAMILY HISTORY

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
CHILDREN	# ALIVE	AGES & HEALTH	# DECEASED	CAUSE OF DEATH		

SIGNATURE

To the best of my knowledge, the above information is complete and correct.

Signature of Patient, Parent, Guardian or Personal Representative

Date

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ACCIDENT INFORMATION FORM

DATE OF ACCIDENT: _____

LAST NAME: _____ FIRST NAME: _____

HOW AND WHERE DID THE ACCIDENT OCCUR? (Be specific) [Lugar de accidente?] _____

LIST EACH AND EVERY BODY PART INJURED AT THE TIME OF THE ACCIDENT: _____

AT THE TIME OF THE ACCIDENT DID YOU?

- Lose consciousness [Perdio el sentido]
- Experience ringing in the ear(s) [Ruido en los oidos]
- Have bruising [Morados]
- Have lacerations [Cortadas]
- Have dizziness [Mareos]

WHAT BODY PARTS ARE YOU BEING SEEN FOR TODAY?

- Neck [Cuello] Pain Tightness Shooting
- Back [Espalda] Pain Tightness Shooting
- Other: _____

WHAT MAKES YOUR PAIN WORSE? [Que su dolor se empeora?]

- Sitting [Sentado]
- Standing [Parado]
- Household chores [Oficio]
- Sex [Sexo]
- Sleeping [Dormir]
- Walking [Caminando]
- Exercise [ejercicio]

Other: _____

CHIROPRACTIC TREATMENT HELPED? [Tratamiento quiropractico ayudo?] Yes No Temporary None

LIST ANY PRIOR INJURIES AND/OR ACCIDENTS [Lesiones o accidentes anteriores]: _____

MOTOR VEHICLE ACCIDENT, only – please complete

Type of vehicle [Tipo de vehiculo]
 Coupe
 Sedan
 SUV
 Other: _____

Other vehicle [Otro vehiculo]
 Coupe
 Sedan
 SUV
 Other: _____

Were you wearing your seatbelt?
 Yes
 No

How fast were you traveling?
[La rapidez con que ud viaja?]

Did you brace for impact?
 Yes
 No

Your position
 Driver [Chofer]
 Front passenger [Pasajero adelante]
 Back passenger [Pasajero atras]
 Right [Derecho]
 Left [Izquierdo]

Point of impact [Impacto]
 Front [Adelante]
 Back [Atras]
Side
 Right [Derecho]
 Left [Izquierdo]

List any body part hit in the vehicle. [Alguna parte de ud golpio el coche.]

Damage to vehicle? [Daños al vehiculo?]
\$ _____

Was the vehicle drivable?
[Carro era manajable?]
 Yes
 No

Ticket issued?
[A quien le dieron el ticket?]
 Yourself [Ud]
 Other driver [Otro chofer]

Police/Ambulance arrive?
[Policia o ambulancia llegaron?]
 Yes
 No

Transported to the hospital?
[Lo transportaron al hospital?]
 Yes
 No

Did airbags deploy?
 Yes
 No

Signature of Patient _____

Date _____

PERSONAL HEALTH INFORMATION All information is kept strictly confidential.

AGE: _____ HEIGHT: _____ WEIGHT: _____ Referring Doctor: _____
(Name) (Phone #)

Pain/Concerns today: _____

Circle any symptoms you currently have or have had in the past:

WOMEN only – Are you pregnant? **YES NO**

GENERAL	ENDOCRINE/GLANDS	HEAD, EYE, EAR, NOSE, THROAT	RESPIRATORY	DIGESTIVE
Change in weight	Heat intolerance	Change in vision	Difficulty breathing	Abdominal pain
Exposure to MRSA	Cold intolerance	Change in hearing	Shortness of breath	Constipation
Recent Illness	Diabetes	Ringing in ears	Coughing up blood	Vomiting
Decrease in exercise tolerance	Excessive thirst	Recent upper respiratory infections	Wheezing/Asthma	Bloating
Chills	Frequent urination	Headaches	Tuberculosis	Diarrhea
Fever	Thyroid problems	Dizziness	Night sweats	Acid reflux
Forgetfulness	Excessive sweating	Lightheadedness	COPD	Difficulty swallowing
		Double vision	Emphysema	Change in appetite
NERVOUS SYSTEM	BLOOD/LYMPH	Blind spots	Lung Cancer	Gastritis
Loss of consciousness	Anemia	Masses in the neck	Persistent cough	Ulcers
Seizures	Bleeding disorders	Nosebleeds		Change in bowel habits
Blackouts	Previous transfusions		GENITO-URINARY	MUSCULOSKELETAL
Numbness/Tingling	Rh incompatibility	CARDIOVASCULAR	Excessive urination	Broken bones
Radiating pain	Lymph node enlargement	Chest pain	Frequent urination	Muscle weakness
Change in speech	Lymph node tenderness	Palpitations	Urgency while urinating	Sprains
Change in coordination		Murmur	Painful urination	Strains
Loss of muscle tone	SKIN	Abnormal rate/rhythm	Blood in urine	Other injuries
Tremors	Skin Cancer	High blood pressure	Kidney stones	
Paralysis	Rash	High cholesterol	Sexually Transmitted Disease	EMOTIONAL STATUS
Shooting pain	Non healing lesion	Heart Disease	Bladder issues	Mood changes
Burning pain	Scaling	History of Aneurysm		Depression
Stroke or TIA	Other skin conditions			Change in memory
	Psoriasis			Anxiety
				Tension
				Bipolar disorder

List all surgeries you have had: _____

Circle any conditions you have or have had in the past:

AIDS/HIV	Cancer	Gallbladder Disease	Kidney Disease	Stroke/TIA
Alcohol Dependency	Cataracts	Glaucoma	Liver Disease	STD
Appendicitis	Chemical Dependency	Gout	Multiple Sclerosis	Thyroid Disease
Arthritis	Diabetes	Heart Disease	Osteoporosis	Ulcers
Bleeding Disorder	Epilepsy/Seizures	Hepatitis	Pneumonia	Varicose Veins
Broken Bones	Other serious illnesses: _____			

Check illnesses which have occurred in any of your **BLOOD RELATIVES**:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Psychiatric Illness
<input type="checkbox"/> Other serious illnesses: _____			

MEDICATIONS/ALLERGIES

List medications you are currently taking: _____

List allergies to medications or substances: _____

HEALTH HABITS

Do you use?	How much?
Tobacco	_____
Alcohol	_____
Illicit Drugs	_____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ Signature of Patient, Parent, Guardian or Personal Representative	_____ Date
_____ Printed Name of Patient, Parent, Guardian or Personal Representative	_____ Relationship to Patient

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CONSENT FOR TREATMENT

I, the undersigned, voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.

The undersigned patient and guarantor, if any, hereby agree to pay all charges from Dr. Nile R. Lestrangle to Dr. Nile R. Lestrangle in accordance with the regular rates and terms of Dr. Nile R. Lestrangle and agree to pay for any charges not covered by any third party payer. Dr. Nile R. Lestrangle files insurance as a courtesy to the patient, but the patient is ultimately responsible for payment of the total incurred charges. The undersigned agree that if this account is turned over to a collection agency or attorney, that the undersigned patient and guarantor, if any, shall be obligated to pay the outstanding balance plus all costs of collection including reasonable attorney fees. The undersigned agree that any overpayments collected on this account may be applied to any delinquent account for which the undersigned patient is legally responsible. The undersigned patient and guarantor, if any, hereby agree that they are jointly and severally liable to pay the entire balance due and that Dr. Nile R. Lestrangle is relying upon the undersigned(s) promise to pay in treating the patient.

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I, the undersigned, hereby authorize and request the release of my medical records to:

DR. NILE R. LESTRANGE
1600 SOUTH FEDERAL HIGHWAY, TENTH FLOOR, POMPANO BEACH, FLORIDA 33062

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Dr. Nile R. Lestrangle and assign to him any and all rights and benefits that I or the patient may have under any policy of insurance including Medical, Automobile, Personal Injury Protection, Workers' Compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to Dr. Nile R. Lestrangle. I understand I am financially responsible to Dr. Nile R. Lestrangle for charges not covered by this assignment.

SIGNATURE AUTHORIZATION

I hereby authorize Dr. Nile R. Lestrangle to furnish to my insurance company of their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of Dr. Nile R. Lestrangle any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

HIPAA INFORMATION AND CONSENT FORM

I request the following restrictions to use or disclosure of my health information: _____

My signature signifies consent and acknowledgement to the terms in the HIPAA Information and Consent Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

NOTICE OF PRIVACY PRACTICES

I have been provided information regarding the privacy practices used by Dr. Nile R. Lestrangle.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Printed Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

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MEDICAL RECORDS AND PHYSICIAN'S LIEN

I do hereby authorize Nile R. Lestrangle, MD office to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Nile R. Lestrangle, MD such sums as may be due and owing them for medical services rendered to me by reason of this accident and by reason of any other bills that are due in their office, and to withhold sums from my settlement, judgment or verdict as may be necessary to pay said doctor's bills in full. I hereby further give a first priority lien to Nile R. Lestrangle, MD upon any and all matters (whether in suit or not) and said funds in and to which I am a claimant as a result of the injuries for which I have been treated, to the extent necessary to satisfy in full Nile R. Lestrangle, MD medical bills to me (including their fee for consultation with my attorney(s) or their staff and/or for testifying or preparing any reports regarding me) and Nile R. Lestrangle, MD attorneys' fees and costs incurred by them in enforcing or obtaining an interpretation of this document (whether they bring suit for same or not, and including the attorney's fees and costs to be awarded to them). I instruct you, my attorney, named herein (and any subsequent or additional attorneys who may represent me) to honor and satisfy this lien in full before disbursing any funds to me or any other claimant against said funds (including yourself).

I fully understand that I am directly and fully responsible to Nile R. Lestrangle, MD for all medical bills submitted by said Doctor for services rendered me and this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover any monies. Nile R. Lestrangle, MD may contract with an insurance plan that you participate in, however, this provider will neither bill or accept payment from that insurance company. Nile R. Lestrangle, MD will rely on Letter of Protection, Personal Injury Protection, Med Pay and if no settlement is reached, to the patient for payment.

I, by signing this agreement, acknowledge that I understand, have consulted with my attorney, and agree to a waiver, which is defined as a voluntary and intentional relinquishment of a known right as to my healthcare plan.

I have been advised that if my attorney does not wish to cooperate in protecting Nile R. Lestrangle, MD's interest, they shall not await payment but will require me to pay on my account and keep it on a current basis, which, in no way will diminish the lien I hereby give to Nile R. Lestrangle, MD.

Patient Signature _____ **Date** _____

Patient Printed Name _____ **SS#** _____

The undersigned being the attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict REGARDLESS OF INSURANCE COVERAGE as may be necessary to honor completely the above referenced lien. The undersigned attorney also agrees that prior to concluding settlement negotiations and prior to disbursement of any settlement, judgment or verdict proceeds; he/she will contact Nile R. Lestrangle, MD's office. Should the undersigned withdraw or be discharged from representing the above named patient, he/she agrees to contact Nile R. Lestrangle within 5 days in writing to apprise them of same.

Attorney Printed Name _____ **Phone** _____

Please return by fax to (954) 788-9307

For Office Use Only

Patient Name (Last, First)

Patient Number

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HEALTH INSURANCE DISCLOSURE/REPRESENTATION FORM

I the undersigned patient, do hereby declare under penalty of perjury and represent and warrant to Dr. Nile R. Lestrangle, and Nile R. Lestrangle, MD, PA, that I do not have any health insurance whatsoever, including but not limited to HMO or PPO insurance, unless I have listed the specific health insurance provider(s) and their information below on this form and provided a copy of my health insurance card(s) to the medical provider referenced in this paragraph.

1. Name of Health Insurance Provider: _____

Address of Health Insurance Provider: _____

Health Insurance Provider Claims Telephone Number: _____

Insurance plan is a: HMO
 PPO
 Other: _____

Group Number: _____ Identification Number: _____

Policy Number: _____

2. Name of Health Insurance Provider: _____

Address of Health Insurance Provider: _____

Health Insurance Provider Claims Telephone Number: _____

Insurance plan is a: HMO
 PPO
 Other: _____

Group Number: _____ Identification Number: _____

Policy Number: _____

Signature of Patient, Parent, Guardian or Personal Representative

Date

Printed Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient