Dizon Wellness Center LLC 2282 Hamburg Tpk, Suite G, Wayne, NJ, 07470-(973) 835-3400

PATIENT INFORMATION & CONDITION FORM

Patient Name:		Today's Date:		
Social Security Number:	Birth Date:		Age:	Gender:
If you are under 18 years of age, who are yo	ur legal parents or gua	ardian?		
Father:		_ Date of Birt	h:/	Phone: ()
Mother:		Date of Birt	h:/	Phone: ()
Guardian:		Date of Birt	h:/	Phone: ()
Who do you normally live with?	☐ Mother and Father	☐ Father	☐ Mother ☐	Legal Guardian ☐ None of these
Marital Status:	low many children? _			
CURRENT ADDRESS				
Street:				
City:		State:		Zip:
Phone ()	_			
OTHER ADDRESSES WHERE YOU RESID	E (e.g., parents' home	, any other add	dress where you	regularly reside)
Street				
City			State	Zip
Phone ()	_			
Occupation:		Employer: _		
Work Address:				
Student at:			Status	S:
Name of Spouse:		Spouse's D	ate of Birth:	
Spouse's Occupation:		Spouse's Employer:		
Spouse's Work Address:			Wor	k Phone:
Spouse is a student at:			State	JS:
Who should we contact in the event of an en	nergency?			Phone:
Address of contact person:				
	**********	******	*********	*****************
How did you learn about us?				
Is your condition or injury due to an accident	or work-related cause	? □YES □	NO Please o	heck ALL that apply.
Did the condition or injury result from	om <i>automobile</i> acciden	t? YES	□NO	
Did it result from a work-related ac	cident or cause?	YES NO(b	oriefly describe):	
If the condition did not result from a	an automobile acciden	t or relate to yo	our work, where	did the accident occur?
Approximately, when did your injury or condi	tion occur?//			

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them. Name:	Describe your condition, symptoms, or t	the purpose of this appointment:				
Name: Type of Practice: Date of Last Visit: /_/ Name: Type of Practice: Date of Last Visit: /_/ Name: Type of Practice: Date of Last Visit: /_/ When? What surgery have you had? When? Serious illnesses or conditions? When? Have you been treated for any health condition by a physician in the last year? YES NO Describe: What medications or drugs are you taking? Have you ever suffered from: Dizziness Arthritis Dizestive Disorders Nervousness Ne	Have you ever had the same or similar condition? YES NO If yes, when and describe:					
Name: Type of Practice: Date of Last Visit:	Please indicate any other healthcare pro	oviders who you've seen for this injury or con	dition, and when you last saw them.			
Date of last physical examination? What surgery have you had? When? Serious illnesses or conditions? When? Have you been treated for any health condition by a physician in the last year? YES NO Describe: What medications or drugs are you taking? Have you ever suffered from: Dizziness	Name:	Type of Practice:	Date of Last Visit://			
When? When?	Name:	Type of Practice:	Date of Last Visit:/			
When? Serious illnesses or conditions? Have you been treated for any health condition by a physician in the last year? YES NO Describe: When? Have you been treated for any health condition by a physician in the last year? YES NO Describe: What medications or drugs are you taking? Have you ever suffered from: Dizziness	Name:	Type of Practice:	Date of Last Visit://			
Serious illnesses or conditions?	Date of last physical examination?					
Describe: What medications or drugs are you taking? Have you ever suffered from: Dizziness Heart Trouble Diabetes Heart Trouble Diabetes Hernia Neuritis Diabetes Hernia Neuritis Diabetes Hornia Neuritis Do you have health insurance? WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Women of Policy Holder: Policy Holder's Date of Birth Policy Holder's Hornia Hornia Neuritis Do you have health insurance? Women of Policy Holder: Policy Holder's Date of Birth Do you have health and accident insurance policies are an arrangement between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand the the estimated responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I wimmediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. Authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.	What surgery have you had?		When?			
Describe:	Serious illnesses or conditions?		When?			
What medications or drugs are you taking? Have you ever suffered from: Dizziness	Have you been treated for any health co	ondition by a physician in the last year?	/ES □ NO			
Have you ever suffered from: Dizziness	Describe:					
Dizziness	What medications or drugs are you taking	ng?				
Backaches Headaches Nervousness Nervousness Headaches Nervousness Heart Trouble Numbness Sinus Trouble Ashma Anemia Anemia Hernia Neuritis Cancer WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? YES NO UNCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN UNCERTAIN Do you have health insurance? YES NO Not Sure Company: Policy Holder's Date of Birth/ Does the policy holder have the insurance through his/her employer? YES NO If yes, who is the employer? Understand and agree that health and accident insurance policies are an arrangement between my insurance company and mysel the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of the property of	Have you ever suffered from:					
□ Heart Trouble □ Numbness □ Sinus Trouble □ Diabetes □ Diabetes □ Asthma □ Neuritis □ Cancer WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN Do you have health insurance? □ YES □ NO □ Not Sure Company: □ Policy Holder's Date of Birth □ / □ Does the policy holder have the insurance through his/her employer? □ YES □ NO □ If yes, who is the employer? □ Industrated and agree that health and accident insurance policies are an arrangement between my insurance company and mysel and the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I wimmediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.	□ Dizziness	☐ Arthritis	☐ Digestive Disorders			
Diabetes	□ Backaches	☐ Headaches	□ Nervousness			
□ Hernia □ Neuritis □ Cancer WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN Do you have health insurance? □ YES □ NO □ Not Sure Company: □ Policy Holder's Date of Birth □ □ Does the policy holder have the insurance through his/her employer? □ YES □ NO If yes, who is the employer? □ Inderstand and agree that health and accident insurance policies are an arrangement between my insurance company and mysell not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand the the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will mediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. They read not strucked to the best of my insurance companies, attorneys, or other payers.	☐ Heart Trouble	□ Numbness	☐ Sinus Trouble			
WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Policy Holder's Date of Birth// Does the policy holder have the insurance through his/her employer? Policy Holder's Date of Birth/_/ Does the policy holder have the insurance through his/her employer? Runderstand and agree that health and accident insurance policies are an arrangement between my insurance company and mysel understand and agree that health and accident insurance policies are an arrangement between my insurance company and mysel understand and agree that health are company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of the estimated responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office. I will mediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account. I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. Authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.	□ Diabetes	☐ Asthma	☐ Anemia			
Policy Holder's Date of Birth/ Does the policy holder have the insurance through his/her employer? YES NO If yes, who is the employer?	☐ Hernia	☐ Neuritis	□ Cancer			
Policy Holder's Date of Birth/ Does the policy holder have the insurance through his/her employer? □ YES □ NO If yes, who is the employer? □ NO If yes, who is the employ	WOMEN ONLY: Are you pregnant or is	there any possibility you may be pregnant?	☐ YES ☐ NO ☐ UNCERTAIN			
I understand and agree that health and accident insurance policies are an arrangement between my insurance company and mysel the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.	Do you have health insurance? YES	S □ NO □ Not Sure Company:				
I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myselestimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I with middle pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. Authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.	Full Name of Policy Holder:	Policy Holder's Date	e of Birth// Does the policy holder			
I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myselestimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.						
The not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I with immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.	****	**********************************	***********			
responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.	not between my insurance company a the estimated responsibility is neither a my actual responsibility as determined company does not pay on my charges immediately pay the balance owing on appear on all accounts over 90 days. It balance on my account, I will be resp	and this office. I agree to pay my estimated a guarantee of payment by my insurance cort by my insurance company upon processing at the estimated rate or within a reasonable my account unless otherwise agreed to in water further understand and agree, that if this office consible for payment and will reimburse this	patient responsibility and further understand that mpany, nor necessarily an accurate reflection of g of my claims. In the event that my insurance period of time, upon request of this office I will writing. I understand that an interest charge may be must take any action to collect an outstanding			
knowledge.	responsible for paying benefits to me, a	nd to any attorney s who may be representir	ng me due to my condition, and to complete any			
Patient's Signature: Date://	I have read, understood, and agree to t knowledge.	he foregoing. The information which I have	provided is true and complete to the best of my			
	Patient's Signature:		Date://			