Tony Tropea, D.C.
www.tonytropeadc.com

Tropea Chiropractic, Inc.

260 S Sunnyvale Ave. #2
Sunnyvale, CA 94086
408-329-9604

WE ARE PLEASED TO WELCOME YOU TO OUR OFFICE

Date ____________________

Patient Information

First Name ____________	Middle Name / MI ____________	Last Name ____________	Date of Birth ____________
Patient Address Line 1 ____________	City ____________	State ____________	Zip ____________
Home Phone ____________	Work Phone ____________	Cell Phone ____________	Email ____________
Sex ____________	Social Security Number ____________	Drivers License # ____________	
Professional Title ____________	Employer Name ____________		
Employer Address Line 1 ____________	Employer City ____________	Employer State ____________	Employer Zip ____________
Emergency Contact Name ____________	Emergency Contact Home Phone ____________	Emergency Contact Cell Phone ____________	Emergency Contact Relationship to Patient ____________
Emergency Contact Address Line 1 ____________	Emergency Contact City ____________	Emergency Contact State ____________	Emergency Contact Zip ____________
If patient is a minor, name of responsible guardian ____________			
How were you referred to our office? ____________			

Primary Insurance Information

Insured First Name ____________	Middle Name / MI ____________	Last Name ____________	Date of Birth ____________
Insured Address ____________	City ____________	State ____________	Zip ____________
Primary Relationship to Insured ____________	Insured SS# ____________	Sex ____________	
Employer Name ____________	Employer Phone ____________		
Primary Insurance Name ____________	Insurance Address ____________	Primary Group No. ____________	Primary Subscriber ID ____________

Insurance Co. Phone

____

Financial Policy

As a courtesy, we do call your insurance company prior to your appointment. Any estimated insurance co-pays, and deductible amount is **due at time services are rendered in order to control cost of billing**. I understand that due to insurance policy changes and/or necessary changes in treatment plans, the insurance may vary from the estimated treatment calculation. I acknowledge that this is an estimate only and that I am ultimately financially responsible for all services rendered, not the insurance company. I also understand that all services are due to be paid in full within (90) days of date of service, whether or not my insurance benefits have been received. Should my account exceed (90) days, an interest rate of %1.5 per month will be charged to my account.

Missed Appointments

We recognize the value of your time, and except in the case of an emergency, you can expect us to serve you. If for some reason you should **miss, reschedule, or cancel** your appointment without notifying our office **24 hours prior** to your appointment, you will be charged for the full rate of your visit.

Authorization

Name

____

I, the above-named, authorized Tony Tropea, DC to examine and provide me with appropriate treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Tony Tropea, DC. I authorize Tony Tropea, DC to release my medical or incidental information that may be necessary for either medical care or in processing applications for financial reimbursement. I understand it is my responsibility to know all rules and restrictions of my insurance policy. It is Tony Tropea, DC's procedure to share Protected Health Information with consulting physicians. We will only exchange minimum necessary Protected Health Information for each transaction.

My signature below is my acknowledgement and consent to the above and the back of this form and certifies that I have filled out this health questionnaire completely and have advised you of all medical problems of which I am aware.

Signature of Patient (or Guardian if patient is a minor)

Date

____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

____

Is this?

○ Work Related
○ Auto Related ○ N/A

DATE PROBLEM BEGAN

____

Current complaint (how you feel today)

○ No Pain 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Unbearable Pain

How often are your symptoms present?

○ 0 - 25% ○ 26 - 50% ○ 51 - 75% ○ 76 - 100%

Can you perform your daily activities?

○ Yes ○ No

(Describe)

____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?

◯ Yes ◯ No

Date(s) taken

____

WHAT AREAS WERE TAKEN?

____

Please check all of the following that apply to you

☐ None Apply

History of Recent Infection
◯ No ◯ Yes

Recent Fever
◯ No ◯ Yes

HIV/AIDS
◯ No ◯ Yes

Diabetes
◯ No ◯ Yes

Corticosteroid Use
◯ No ◯ Yes

Birth Control Pills
◯ No ◯ Yes

High Blood Pressure
◯ No ◯ Yes

Stroke (date)
◯ No ◯ Yes

Dizziness/Fainting
◯ No ◯ Yes

Numbness in Groin/Buttocks
◯ No ◯ Yes

Urinary Retention
◯ No ◯ Yes

Stroke

____

Aortic Aneurysm
◯ No ◯ Yes

Cancer/Tumor
◯ No ◯ Yes

Osteoporosis
◯ No ◯ Yes

Recent Trauma
◯ No ◯ Yes

Prostate Problems
◯ No ◯ Yes

Frequent Urination
◯ No ◯ Yes

Pregnancy
◯ No ◯ Yes

# of births

____

Abnormal Weight
◯ No ◯ Yes

Abnormal Weight
◯ Gain ◯ Loss

Epilepsy/Seizures
◯ No ◯ Yes

Visual Disturbances
◯ No ◯ Yes

History of Low/Mid Back Pain
◯ No ◯ Yes

History of Neck Pain
◯ No ◯ Yes

Arthritis
◯ No ◯ Yes

History of Alcohol Use
◯ No ◯ Yes

History of Tobacco Use
◯ No ◯ Yes

Surgeries/Medications
◯ No ◯ Yes

Surgeries/Medications:

____

Family History

☐ **Cancer** ☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Cardiovascular Problems/Stroke**

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature

Date

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