

## Patient Information Sheet

### Personal Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Initial Office Visit Date: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Code Ethnicity: \_\_\_\_\_  
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 State \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Auto Insurance company Name, Address, & Telephone #: \_\_\_\_\_

\* Please note that we do not file with your private insurance in personal injury cases. \_\_\_\_\_ Sign.

### 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 am 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

## 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: _____
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#### 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)

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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): \_\_\_\_\_

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Test (MRI, CT scan, EMG, etc.....) (type and date): \_\_\_\_\_

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**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: \_\_\_\_\_

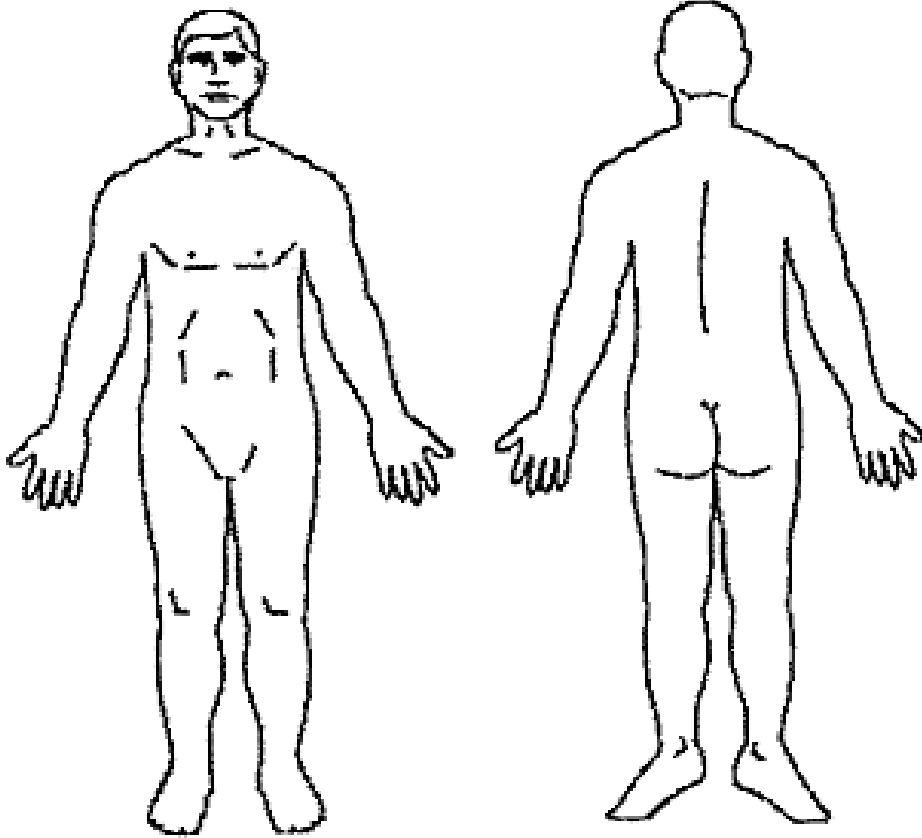
Do you use recreational drugs?    Yes    No

Please mark on the diagram below where your pain occurs

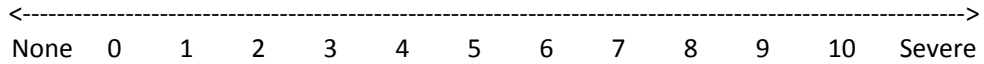
Dull Pain – “+”  
Numbness – “N”

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\*\*



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

## Cancellation and No Show Policy

908 New Hampshire Ave., NW Ste 500  
Washington, DC 20037  
Phone # 202-296-3555  
Fax # 202-296-0214

1515 Chain Bridge Rd, Ste 102  
McLean, VA 22101  
Phone # 703-506-8471  
Fax # 703-506-8475

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!**

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Patient Name (please print)

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Patient Signature

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Date

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Employee Name (please print)

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Employee Signature

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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 # 202-296-0214

1515 Chain Bridge Rd, Ste 102  
McLean, VA 22101  
Phone # 703-506-8471  
Fax # 703-506-8475

**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 NOT 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