W E L C O M E

# WELCOME TO BUKATY FAMILY CHIROPRACTIC, PC
## We are happy to be taking care of you today!

**PATIENT INFORMATION**

Date: ______________ DOB: ______________ Patient SS#: ______________

Name: ______________________________

Address: ______________________ City/State/Zip: ______________________

Home Phone: ______________________ Cell: ______________________

Single Married Widowed Spouse Name: ______________________

Employer: ______________________ Phone: ______________

Occupation: ______________________ E-Mail Address: ______________________

Who may we thank for referring you to us? ______________________

**INSURANCE**

Insurance Company: ______________________ ID#: ______________

Group #: ______________ Person Responsible for Account: ______________

**ASSIGNMENT & RELEASE**

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________ & assign directly to *Bukaty Family Chiropractic* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party: ______________________ Date: ______________

**ACCIDENT INFORMATION**

Is condition due to an accident: Yes No Type of Accident: Auto Work Home Other

Date of Accident: ______________ Did you report this accident: Yes No

Reported to Whom: ______________________

**PATIENT CONDITION**

Reason for Visit: ______________________

How Long: ______________ How Often: ______________

Is it constant or random: ______________ At Night: ______________

Is this condition getting progressively worse? Yes No

Rate the severity of your pain on a scale of 1 (least pain) to 10 (worst pain): __________

Type of pain (circle all that apply): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling

Does the pain interfere with: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform (circle all that apply):

Sitting Standing Walking Bending Lying Down Stairs

# BUKATY FAMILY CHIROPRACTIC, PC

Dr. Christina P. Bukaty
4269 St. Francis Dr, Hamburg, NY 14075
Tele: (716) 627-3668 Fax: (716) 627-2332


## FINANCIAL POLICY AGREEMENT

Our first concern in this office is to provide you, our patient, with excellent chiropractic care. If you have Chiropractic Insurance, we are interested in you receiving maximum benefits.

However, please be advised:

1. **Your Insurance Policy is a legal contract between you, your employer and the Insurance Company. We, as healthcare providers, are NOT a party to that contract.**
2. We are contracted in-network with: Independent Health, Blue Cross Blue Shield, Empire, Aetna, United Health Care & Pomco. We also accept Worker's Compensation, No Fault and Medicare.
3. "Usual & Customary" is a term used by the Insurance Company instead of **"our benefits are low."** Usual & customary fees are reviewed on an average of once every ten years. The key is, you will get back only what your employer puts in...less profits of the insurance company.
4. **You remain ultimately responsible for all charges incurred in this office.**

☐ **Insurance**: If you have insurance that covers chiropractic care, and our office is in-network with your insurance, we will submit your claim to your insurance company. Please note that your designated chiropractic co-pay will be paid in full to our office at each visit. You will be responsible for payment of any non-covered amounts your insurance company does not pay to our office including deductibles and co-insurances.

Insurance Company ______________________ ID ______________________

Card Holder Name ______________________ Birthdate ______________________

Card Holder's Employer Name & Address ______________________

______________________

☐ **No Insurance**: If you do not have health insurance, have out-of-network coverage, **or decide to OPT OUT of using your health insurance policy**, you will be responsible for payment of our regular office fees at time of service. You may also purchase one of our pre-paid visit plans*. ***Please note that our office WILL NOT BACK BILL ANY CLAIIM DATES if you decide to utilize your health insurance policy in the future.*** ______ **initial**

*Pre-paid visit plans, co-payments, & special discounts **cannot** be submitted to your insurance company for reimbursement *but they can be submitted to a flex spending account (FSA) for reimbursement.*

**Having health insurance does NOT guarantee payment of services.**

For your convenience, we accept cash, personal checks*, MasterCard and Visa. **please note that any personal checks returned for non-sufficient funds will be charged an additional fee.*

All questions regarding insurance and other financial matters should be addressed to our Office Manager or our Medical Biller. We want you to be comfortable dealing with these matters and believe open communication will enhance the positive outcome we all desire.

I, (print name) ______________________ have read & understand & agree to the above policies.

Patient Signature: ______________________ Date: __________

Office Manager Approval: ______________________ Date: __________

**Bukaty Family Chiropractic**
Dr. Christina P. Bukaty
4269 St. Francis Drive
Hamburg, NY 14075
716-627-3668

## *TERMS OF ACCEPTANCE*

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, ______________________ have read and fully understand the above statements.
*(print name)*

*All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.*

I therefore accept chiropractic care on this basis.

________________________________ ______________________
*(signature)* *(date)*

## *Consent to evaluate and adjust a minor child*

I, ______________________________ being the parent or legal guardian of ___________________________ have read and fully understand the above terms of acceptance and hereby grand permission for my child to receive chiropractic care.

## *Pregnancy Release*

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation.

______________________________(signature) ______________________(date)

# BUKATY FAMILY CHIROPRACTIC
4269 St. Francis Dr, Hamburg, NY 14075
TELE: (716) 627-3668
HEALTH HISTORY

Please fill out the appropriate paperwork.

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition

_______________________________________________

Date of Last: Physical Exam ________ Spinal X-Ray ________ Blood Test __________
Spinal Exam ________ Chest X-Ray ________ Urine Test __________
Dental X-Ray ________ MRI, CT-Scan, Bone Scan ________

**Place mark on "Yes" or "No" to indicate if you have had any of the following:**

| Condition | | Condition | | Condition | | Condition | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐Yes ☐ No | Emphysema | ☐Yes ☐ No | Miscarriage | ☐Yes ☐ No | Scarlet Fever | ☐Yes ☐ No |
| Alcoholism | ☐Yes ☐ No | Epilepsy | ☐Yes ☐ No | Mononucleosis | ☐Yes ☐ No | Stroke | ☐Yes ☐ No |
| Allergy Shots | ☐Yes ☐ No | Fractures | ☐Yes ☐ No | Multiple Sclerosis | ☐Yes ☐ No | Suicide Attempt | ☐Yes ☐No |
| Anemia | ☐Yes ☐ No | Glaucoma | ☐Yes ☐ No | Mumps | ☐Yes ☐ No | Thyroid Problems | ☐Yes ☐ No |
| Anorexia | ☐Yes ☐ No | Goiter | ☐Yes ☐ No | Osteoporosis | ☐Yes ☐ No | Tonsillitis | ☐Yes ☐ No |
| Appendicitis | ☐Yes ☐ No | Gonorrhea | ☐Yes ☐ No | Pacemaker | ☐Yes ☐ No | Tuberculosis | ☐Yes ☐ No |
| Arthritis | ☐Yes ☐ No | Gout | ☐Yes ☐ No | Parkinson's Disease | ☐Yes ☐ No ☐Yes ☐ No | Tumors, Growths | ☐Yes ☐ No |
| Asthma | ☐Yes ☐ No | Heart Disease | ☐Yes ☐ No | Pinched Nerve | ☐Yes ☐ No | Typhoid Fever | ☐Yes ☐ No |
| Bleeding Disorders | ☐Yes ☐ No | Hepatitis | ☐Yes ☐ No | Pneumonia | ☐Yes ☐ No | Ulcers | ☐Yes ☐ No |
| Breast lump | ☐Yes ☐ No | Hernia | ☐Yes ☐ No | Polio | ☐Yes ☐ No | Vaginal Infections | ☐Yes ☐ No |
| Bronchitis | ☐Yes ☐ No | Herniated Disk | ☐Yes ☐ No | Prostate Problems | ☐Yes ☐ No ☐Yes ☐ No | Venereal Disease | ☐Yes ☐ No |
| Bulimia | ☐Yes ☐ No | Herpes | ☐Yes ☐ No | Prosthesis | ☐Yes ☐ No | Whooping Cough | ☐Yes ☐ No |
| Cancer | ☐Yes ☐ No | High Cholesterol | ☐Yes ☐ No | Psychiatric Care | ☐Yes ☐ No | Other ____________ | |
| Cataracts | ☐Yes ☐ No | Kidney Disease | ☐Yes ☐ No | Rheumatoid Arthritis | ☐Yes ☐ No | ____________ | |
| Chemical Dependency | ☐Yes ☐ No | Liver Disease | ☐Yes ☐ No | Rheumatic Fever | ☐Yes ☐ No | | |
| Chicken Pox | ☐Yes ☐ No | Measles | ☐Yes ☐ No | | | | |
| Diabetes | ☐Yes ☐ No | Migraine Headaches | ☐Yes ☐ No ☐Yes ☐ No | | | | |

| Exercise | Working Activity | Habits |
|---|---|---|
| ☐ None | ☐ Sitting | ☐ Smoking Packs/Day ______ |
| ☐ Moderate | ☐ Standing | ☐ Alcohol Drinks/Weeks ______ |
| ☐ Daily | ☐ Light Labor | ☐ Coffee/Caffeine Cups /Day ______ |
| ☐ Heavy | ☐ Heavy Labor | ☐ High Stress Level Reason ______ |

**Are you Pregnant?** ☐Yes ☐ No **Due Date** ______________________________

| **Injuries/Surgeries you have had** | **Description** | **Date** |
|---|---|---|
| Falls | ____________________ | ________________ |
| Head Injuries | ____________________ | ________________ |
| Broken Bones | ____________________ | ________________ |
| Dislocations | ____________________ | ________________ |

| MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| Pharmacy Name ____________ | ____________ | ____________ |
| Pharmacy Phone ____________ | ____________ | ____________ |

## Bukaty Family Chiropractic 4269 St. Francis Dr. Hamburg, NY 14075

*Name* ____________________

*Please circle if you have any of these HEALTH warning signals.*

| | | |
|---|---|---|
| Headaches (yes, no) | (mild,moderate,severe) | When?____________ |
| Dizziness (yes, no) | (mild,moderate,severe) | When?____________ |
| Blurred Vision (yes, no) | (mild,moderate,severe) | When?____________ |
| Concentration (yes, no) | (mild,moderate,severe) | When?____________ |
| Depression (yes, no) | (mild,moderate,severe) | When?____________ |
| Nervousness (yes, no) | (mild,moderate,severe) | When?____________ |
| Difficulty Sleeping (yes, no) | (mild,moderate,severe) | When?____________ |
| Loss of energy (yes, no) | (mild,moderate,severe) | When?____________ |
| Buzz/Ring in ears (yes, no) | (mild,moderate,severe) | When?____________ |
| Heart Palpitations (yes, no) | (mild,moderate,severe) | When?____________ |

### GENERAL PROBLEMS

*Subluxated Vertebrae can cause irritation to different nerve fibers that can affect any organ or tissues causing conditions now or in the future.*

| | | |
|---|---|---|
| Head | (mild,moderate,severe) | When? ____________ |
| Sinuses | (mild,moderate,severe) | When? ____________ |
| Neck Pain (yes, no) | (mild,moderate,severe) | When?____________ |
| Shoulder Problems (yes, no) | (mild,moderate,severe) | When?____________ |
| Upper Back (yes, no) | (mild,moderate,severe) | When?____________ |
| Mid Back (yes, no) | (mild,moderate,severe) | When?____________ |
| Chest Pain (yes, no) | (mild,moderate,severe) | When?____________ |
| Heart/ High High BP (yes, no) | (mild,moderate,severe) | When?____________ |
| Lung (yes, no) | (mild,moderate,severe) | When?____________ |
| Respiratory (yes, no) | (mild,moderate,severe) | When?____________ |
| Indigestion (yes, no) | (mild,moderate,severe) | When?____________ |
| Bladder (yes, no) | (mild,moderate,severe) | When?____________ |
| Liver (yes, no) | (mild,moderate,severe) | When?____________ |
| Kidney (yes, no) | (mild,moderate,severe) | When?____________ |
| Urinary (yes, no) | (mild,moderate,severe) | When?____________ |
| Colon (yes, no) | (mild,moderate,severe) | When?____________ |
| Constipation (yes, no) | (mild,moderate,severe) | When?____________ |
| Low Back (yes, no) | (mild,moderate,severe) | When?____________ |
| Hip Pain (yes, no) | (mild,moderate,severe) | When?____________ |
| Leg Pain/Cramps (yes, no) | (mild,moderate,severe) | When?____________ |
| Poor Circulation (yes, no) | (mild,moderate,severe) | When?____________ |
| Thyroid (yes, no) | (mild,moderate,severe) | When?____________ |

Disorders (Seasonal, hyperactivity, other) (yes, no) (mild,moderate,severe) When?____________

***The vast majority of our patients have experienced literally dozens of impacts that could cause subluxated vertebrae. Car accidents, sprains, strains, and falls can cause major displacements of the spine (subluxations), which may result in abnormal health conditions.***

Please list car accidents (State year or approx. years happened ago).

______________________________________________________________

______________________________________________________________

Please list any significant falls, sprain, or strains ______________________________

Please list medications ______________________________________

Please list Diagnostic Tests ____________________________________

Do/Did you or mother/father/brother/sister has/had CANCER, CARDIOVASCULAR DISEASE, STROKE, or DIABETES?

______________________________________________

# Bukaty Family Chiropractic, P.C.

DR. CHRISTINA P. BUKATY
*Doctor of Chiropractic*

*For Appointment Call:*
716•627•3668
716•627•2332 FAX
716•771•2320 TEXT

*Visit Our Website:*
www.bukatychiropractic.com


Dear Patients,

As the age of technology keeps growing, our office would like to be a part of that growth. Therefore, we are in the process of setting our patient software up to be able to help us help you – by texting reminders and emailing right from your patient account.

In order for us to do this, we need the information below authorized from you to put in our computer system.

Automatic texting of appointment reminders:

____________________________________________
Patient Name – please print

____________________________
Cell Phone Number

____________________________
Cell Phone Carrier (ex: Verizon, Sprint, etc)

____________________________________________
Email address – please print legibly

I hereby authorize BUKATY FAMILY CHIROPRACTIC to text the above cell phone number for appointment reminders. ________ please initial

I hereby authorize BUKATY FAMILY CHIROPRACTIC to email me upcoming events and other information, notices. ________ please initial

Please note: the appointment texting through our patient software program is for appointment reminders only! Please still feel free to use our regular texting line for information, appointment changes and cancellations, etc. That number is 771-2320.

If you have any questions, please feel free to speak with Sue.

Thank you!!!

*CHIROPRACTIC:*
- Family
- Pediatric
- Pregnancy
- Professional Athletes
- Neck Conditions

*SPINAL DECOMPRESSION:*
- Lumbar
- Cervical
- Rehabilitation

*MASSAGE THERAPY:*
- Nutritional Supplements
- Laser Therapy
- Vibration Therapy