

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

PATIENT INFORMATION

W
Date: _____ DOB: _____ Patient SS#: _____
Name: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Cell: _____
Single Married Widowed Spouse Name: _____
E
Employer: _____ Phone: _____
Occupation: _____ E-Mail Address: _____
Who may we thank for referring you to us? _____

INSURANCE

L
Insurance Company: _____ ID#: _____
Group #: _____ Person Responsible for Account: _____

ASSIGNMENT & RELEASE

C
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

O
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

M
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
E
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
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:

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

Exercise <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	Working Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	Habits <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Weeks _____ <input type="checkbox"/> Coffee/Caffeine Cups /Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Are you Pregnant? Yes No

Due Date _____

Injuries/Surgeries you have had

- Falls
- Head Injuries
- Broken Bones
- Dislocations

Description

Date

_____	_____
_____	_____
_____	_____

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

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 or 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 grant 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)

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. As an added service to you, our office will process your insurance claim for you.

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 not in-network members of BCBS, Community Blue, Independent Health, Univera, Empire, Aetna or Cigna (many others included also). Therefore, any coverage you may have for services provided at this office will be deemed **"Out of Network Coverage"** by your Insurance Company.
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 out-of-network chiropractic visits, we will be glad to submit your claim to your insurance company. Please note that ALL fees will be paid in full to our office until your insurance company responds back to us about your benefit coverage. If your insurance company does not respond to us within 60 days of submission, we will submit a second time. If your insurance company still does not respond to us after this second submission, you will then be responsible for submitting your claim for reimbursement. You are also responsible for payment of any non-covered amounts your insurance company does not pay to our office including deductibles and co-insurances.

No Insurance: If you do not have health insurance, or choose not to use your out-of-network coverage, 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.

Pre-paid visit plans and co-payments **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 whether in-network or out-of-network.

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 \$20 fee.*

All questions regarding insurance and other financial matters should be addressed to our Office Manager. 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: _____

Insurance: _____

Office Manager Approval: _____ Date: _____