

Trinity Health Center New Patient Protocol & Checklist

Dr. Segreto does not accept every patient that consults with him. He also is respectful of your time and resources and therefore has put together the following steps to help insure that you are a candidate for care at our office.

1. ____ Go to trinityhealthcenter.com and on the main page scroll down and watch the second video entitled *New Patient Special Report*. (You are welcomed to watch all the videos but the Special Report video is required.)

The following information must be completed and sent back to us:

2. ____ Case history filled out completely (5 pages total).
3. ____ Consent, financial, and e-records forms (4 pages total)
4. ____ Any other recent reports (MRI, blood work, etc.)

Send ALL forms via any of these methods:

Scan and email to: trinityofficemanager@yahoo.com

Or

Fax: 732-270-8447

Or

Mail: Trinity Health Center, 882 Bay Ave, Toms River, NJ 08753

We will contact you to confirm that your paperwork has been received. If sent outside of our normal hours, we will contact you when we return to the office.

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU.

Name _____ Birthday _____ Sex M F

Address _____ City _____ State _____ Zip _____

Email _____ Soc. Sec. # _____

Home # _____ Cell # _____ Work # _____

Occupation _____ Employer _____

Marital Status M S D W Spouse's Name _____ Children, Ages _____

Have you ever been to a Chiropractor before? _____ If yes, when? _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Does anything make it feel worse? _____

Does anything make it feel better? _____

Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Other doctors or therapists who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

Medications, dosage and frequency: _____

Have you been in an auto accident or had any other personal injury? Yes No Describe _____

Medicare Number if applicable _____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name _____ Number _____ Date _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

<u>GENERAL</u>	<u>NOW</u>	<u>PAST</u>	<u>THROAT</u>	<u>NOW</u>	<u>PAST</u>	<u>GASTROINTESTINAL</u>	<u>NOW</u>	<u>PAST</u>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
<u>SKIN</u>			<u>NECK</u>			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<u>BREASTS</u>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<u>HEAD</u>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<u>LUNGS</u>			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
<u>EARS</u>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<u>HEART</u>			Urine Color		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between		
<u>NOSE</u>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Periods	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type _____		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<u>BLOOD</u>			Age at First Period _____		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Cycle _____		
<u>MOUTH</u>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow _____		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births _____		
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages _____		
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions _____		
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light		
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period _____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear _____		
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam _____		
						Last Mammogram _____		
						Last Prostate Exam _____		

NEUROLOGIC NOW PAST

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

ENDOCRINE

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

IMMUNIZATION/VACCINATION

- DPT
- Mumps
- Smallpox
- Thyroid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

BLOOD TYPE

- A+ A-
- B+ B-
- AB+ AB-
- O+ O-
- Other _____

BLOOD TRANSFUSIONS

- Date _____
- Date _____
- Date _____
- Date _____

PSYCHIATRIC NOW PAST

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

- | | |
|--|--|
| Hay Fever <input type="checkbox"/> | Epilepsy <input type="checkbox"/> |
| Mumps <input type="checkbox"/> | Paralysis <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Allergies <input type="checkbox"/> | Mental Illness <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Alcoholism <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Tumor <input type="checkbox"/> | Nervous Breakdown <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Migraine <input type="checkbox"/> |
| Leukemia <input type="checkbox"/> | Gout <input type="checkbox"/> |
| Heart Trouble <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> |
| Varicose Veins <input type="checkbox"/> | Prostate Problems <input type="checkbox"/> |
| Phlebitis <input type="checkbox"/> | Sexual Problems <input type="checkbox"/> |
| Hypertension <input type="checkbox"/> | Gonorrhea <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | Syphilis <input type="checkbox"/> |
| Ulcers <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Jaundice <input type="checkbox"/> | Bladder Trouble <input type="checkbox"/> |
| Skin Trouble <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> |
| Gallstones <input type="checkbox"/> | Kidney Infections <input type="checkbox"/> |
| Liver Trouble <input type="checkbox"/> | Emphysema <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/> | <input type="checkbox"/> |
| Parasites <input type="checkbox"/> | <input type="checkbox"/> |

Date of Last Chest X-Ray _____ Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Allergies: _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per week _____ Type _____

Smoking Current Previous Packs/Day _____ No. of years _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine Cups/Day _____ No. of Years _____
(Coffee, Tea, Cola)

Aspirin No./Day _____ No. of Years _____ Others _____

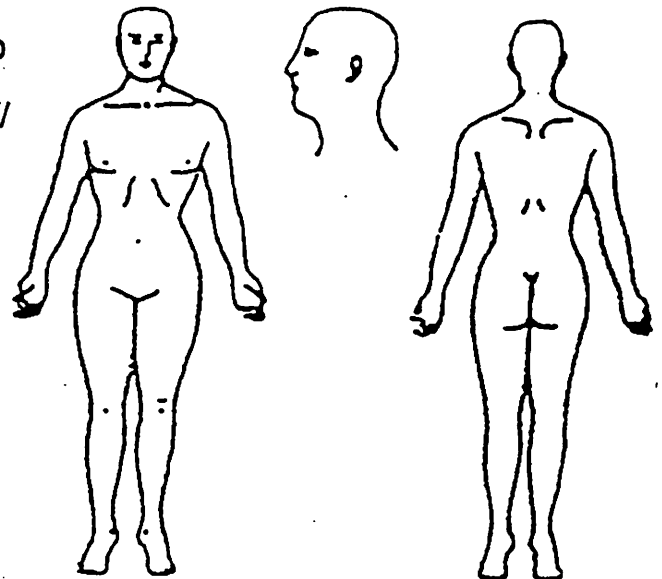
MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO RIGHT. Use the following symbols:
 Aches $\wedge \wedge \wedge$ Numbness oooo Pins/Needles Stabbing ////

MARK AN "X" ON THE LINES:
 How bad are your symptoms now?

_____ None _____ Most Severe

How bad have they been in the past?

_____ None _____ Most Severe



Patient Name _____ Number _____ Date _____ 4

Name _____ Your Age Today _____

In constructing care plans for his patients, Dr. Segreto uses several natural, drug-free methods and products to help his patients get well. If necessary, are you willing to:

Please circle your answer.

Take specific nutritional supplements to help your condition? Y N

Make dietary changes if necessary? Y N

Use specific homeopathic remedies as recommended by Dr. Segreto? Y N

Do specific stretches or exercises to aid in your recovery? Y N

Regardless of whether you think they are affecting your health or not, what stress factors are you currently experiencing in your life? _____

Do you currently vape or use any type of e-cigarette? Y N

If yes, what are you using _____ How often _____

How much water do you drink every day (WATER – not juice, coffee, tea, or any other drink)? _____

Do you drink diet sodas, or use any other artificial sweeteners? Y N

If yes, how much? _____

Do you drink regular sodas or other sweet drinks? Y N

If yes, how much? _____

Do you eat fast food? Y N

If yes, how often? _____

Do you have a bowel movement every day? Y N

If not, how often? _____

Do you ever experience heartburn or reflux Y N

If yes, how often? _____

How many rounds of antibiotics have you taken in the last 12 months? _____

How many rounds of antibiotics have you taken in the last 5 years? _____

How many rounds of antibiotics have you taken in your lifetime (estimate)? _____

Please list any other past or current long courses of medication. _____

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Trinity Health Center, L.L.C. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (732) 270-6222. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Print Patient's Name

X _____
Patient's Signature

X _____
Other Than Patient, Print Name & Relationship

X _____
Witness

OFFICE FINANCIAL POLICY

1. If You Do Not Have Insurance: All payments are expected at the time of service. Your personal balance may not exceed \$100 at any time or care may be terminated.

2. If You Have Insurance: Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We require you to call your insurance so you know what your benefits are. We will bill your insurance plan and will collect any copay, co-insurance, or deductible **due** by you at the time of service.

If your health plan determines a service to be “not covered” or is not an eligible expense under your plan, you will be responsible for the complete charge. Payment is due upon receipt of that statement from your insurance company.

Pre-authorization may be required from your insurance company for chiropractic care. If you are not sure pre-authorization is required for your plan, please contact your insurance company to verify your plan benefits. Failure to provide Trinity Health Center, with proper authorization may result in delay or rescheduling your appointment. You will also be financially responsible for all services related to your visit.

3. There will be a \$25.00 charge for any returned checks.

Today's Date _____

Patient's Printed Name _____

Patient's or Authorized Signature _____

Office Signature _____

IMPORTANT INSURANCE INFORMATION

While we make every effort to assist you with your insurance questions and submissions, you must understand that it is **YOUR** responsibility to verify your insurance coverage and to understand the extent of that coverage.

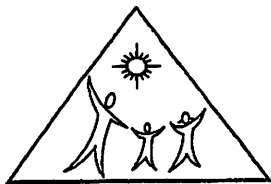
Insurance companies are obligated to YOU, THE INSURED, and not to our office. It is often difficult or impossible for us to get information regarding your specific insurance coverage for our office. Together, we can make sure you know what is covered and what is not covered at Trinity Health Center, L.L.C.

This office has agreed to accept assignment on your insurance claims. This is done as a courtesy to you so that you don't have to put out your own money and wait for reimbursement. From time to time, an insurance company will make an error and send a check directly to you. We hope that this doesn't happen, but we want to be sure that there is no misunderstanding in the event that it does.

I understand the above Important Insurance Information and that any checks that I receive from my insurance company for services that I have received at Trinity Health Center, L.L.C. must be signed over and brought to the office for payment on my account.

Name _____

Signed _____ Date _____



TRINITY HEALTH CENTER
*Non-Surgical Solutions for Pain &
 Chronic Health Problems*

TRINITY HEALTH CENTER, L.L.C.

FRANK SEGRETO, D.C.

882 Bay Avenue

Toms River, NJ 08753

Telephone: (732) 270-6222

Fax: (732) 270-8447

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White -Caucasian Native
 Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ / _____

To all of our patients,

Welcome to the next stage of Electronic Health Records!

You will receive a Government Mandated email from us
TRINITY HEALTH CENTER (noreply@dreamehr.com)

All you have to do to open it is, put your **legal** name all in
lower case, no spaces, where asked.

ie Robert Smith would be robertsmith

ie LOGIN: bblyoe244xV1sDrYXeDZkJKWviaW

 PASSWORD: robertsmith

Please do not be concerned if you cannot open the email. Just let
us know on your next visit.

Thank-you for your help,

-Dr. Frank