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 third 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.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam		_____
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐ Heavy ☐ Mod ☐ Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

Patient Name_____ Number _____ Date _____

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	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

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

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

Date of Last Chest X-Ray _____ ☐ Normal ☐ Abnormal

Last TB Skin Test _____ ☐ Normal ☐ Abnormal

Allergies: _____

_____

_____

_____

_____

Patient Name_____ Number _____ Date _____

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 _____

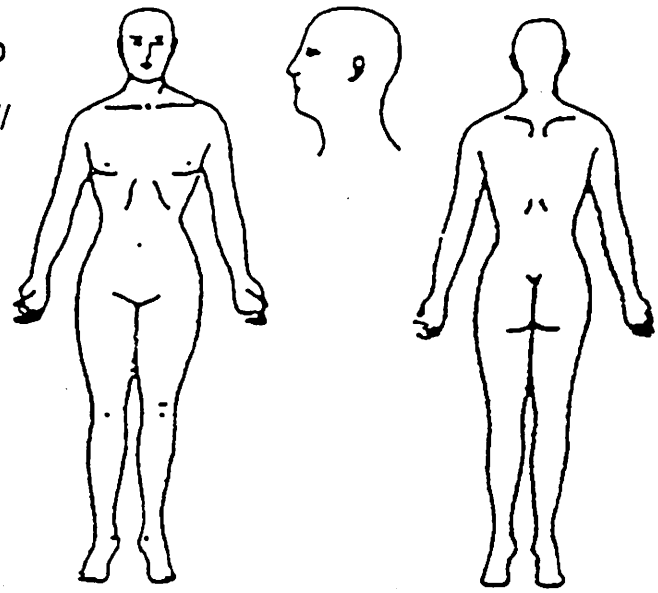
Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

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

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

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

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO RIGHT. Use the following symbols:
Aches ΛΛΛΛ 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 _____

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 by 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 or 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
Frank Segreto, D.C.
trinityhealthcenter.com

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:_____/_____

882 Bay Avenue
Toms River, NJ 08753-3549
(732) 270-6222 Fax: (732) 270-8447

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