

Patient Summary Form

PSF-750 (Rev.2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.
*Fax number may vary by plan.

Patient Information

Patient name Last First MI			<input type="radio"/> Female <input type="radio"/> Male	Patient date of birth		
Patient address				City	State	Zip code
Patient insurance ID#		Health plan		Group number		
Referring physician (if applicable)			Date referral issued (if applicable)		Referral number (if applicable)	

Provider Information

EXUM CHIROPRACTIC CLINIC P.A.				592120066		
1. Name of the billing provider or facility (as it will appear on the claim form)				2. Federal tax ID(TIN) of entity in box #1		
3. Name and credentials of the individual performing the service(s)						
				5. NPI of entity in box #1 11912179680		6. Phone number 407-423-0038
7. Address of the billing provider or facility indicated in box #1 3541 EDGEWATER DR				8. City ORLANDO		9. State FL
						10. Zip code 32804

Provider Completes This Section:

Date you want THIS submission to begin:		Cause of Current Episode		Date of Surgery		Diagnosis (ICD code)	
<input type="text"/>		<input type="radio"/> 1 Traumatic <input type="radio"/> 2 Unspecified <input type="radio"/> 3 Repetitive <input type="radio"/> 4 Post-surgical <input type="radio"/> 5 Work related <input type="radio"/> 6 Motor vehicle		<input type="text"/> <input type="text"/> <input type="text"/>		Please ensure all digits are entered accurately 1° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Patient Type		DC ONLY		Type of Surgery		Current Functional Measure Score	
<input type="radio"/> 1 New to your office <input type="radio"/> 2 Est'd, new injury <input type="radio"/> 3 Est'd, new episode <input type="radio"/> 4 Est'd, continuing care		Anticipated CMT Level <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943		<input type="radio"/> 1 ACL Reconstruction <input type="radio"/> 2 Rotator Cuff/Labral Repair <input type="radio"/> 3 Tendon Repair <input type="radio"/> 4 Spinal Fusion <input type="radio"/> 5 Joint Replacement <input type="radio"/> 6 Other		Neck Index <input type="text"/> DASH <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/>	

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

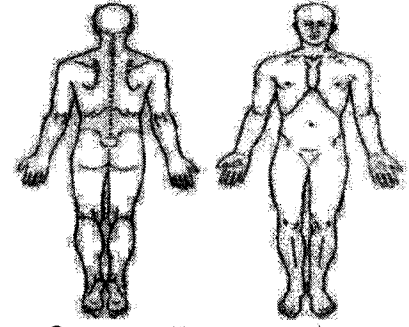
4. How often do you experience your symptoms?
 1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

6. How is your condition changing, since care began at this facility?
 0 N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better

7. In general, would you say your overall health right now is...
 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Indicate where you have pain or other symptoms:



Patient Signature: X Date: _____