13701 Cypress Terrace Cir
Fort Myers, FL 33907
PH: (239) 277-1655 | FX: (239) 277-1255

PATIENT INTAKE FORM

Multi-Care Medical "Of SW Florida"

PATIENT DEMOGRAPHICS AND HISTORY:

Full Name: _____ **Today's Date**: _____

Date of Birth: _____ **Age:** ____ **Sex**: ☐ Male ☐ Female **SS#:** _____

Address: _____ **City/ST/ZIP**: _____

Phone #: _____ **Email**: _____@_____ ._____

☐ **I authorize to receive email/text messages for appointment and general health reminders from this office.**

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name: _____ **Spouse Phone**: _____

Pharmacy: _____ **Phone #:** _____

Emergency Contact Name: _____ **Relationship**: _____ **Phone #**: _____

☐ **If a family member/friend asks to speak to you, we can tell them you are here**

I am taking: ☐ Blood Pressure Medication ☐ Aspirin ☐ Muscle Relaxers ☐ Blood Thinners

Have you ever had any of the following?

☐ Heart Attack/Stroke	☐ Heart Surgery/Pacemaker	☐ Heart Disease	☐ Alcohol Abuse
☐ Drug Abuse	☐ Shingles	☐ Cancer	☐ Venereal Disease
☐ Sinus Problems	☐ Respiratory Issues	☐ HIV/Aids	☐ Kidney Problems
☐ Diabetes	☐ Glaucoma	☐ Arthritis	☐ Anemia
☐ Asthma	☐ High/Low Blood Pressure	☐Hepatitis	☐ Fainting / Seizures
☐ Ulcer/ Colitis	☐ Psychiatric Problems	☐Other(s):	

Do you have any metal in your body? ☐ No ☐ Yes, I have _____

Medical Condition(s): _____

Allergies: _____

List Previous Surgeries/Treatments With Dates: _____

_____

List Any Past Serious Accidents With Dates:_____

_____

Family Health History (Cancer, High Blood Pressure/Heart Disease/Etc):

_____

Do you take supplements or vitamins? ☐ Yes ☐ No **Do You Exercise?** ☐ Yes ☐ No

Are you on a Special diet? ☐ Yes ☐ No **Do you smoke?** ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No **Last menstrual cycle:** _____

TODAY'S VISIT REASON:

☐ Auto Accident ☐ Slip/Fall ***If it was an accident, please be sure to complete the Accident Information section below***

☐ Work ☐Sports ☐ Chronic

Are you experiencing pain? ☐ YES ☐ NO **Date the pain began:** _____

Is the pain getting worse? ☐ YES ☐ NO **Is the pain** ☐ Constant ☐ Come & Go

ACCIDENT INFORMATION: **Date of accident: _____ @ ___:___ ☐ AM ☐ PM**

I was the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Number of people in the vehicle? _____ **Did the police come to the scene?** ☐ Yes ☐ No

Is there a police report? ☐ Yes ☐ No **Were you wearing your seatbelt?** ☐ Yes ☐ No

Witnesses? ☐ Yes ☐ No **Did airbags deploy?** ☐ Yes ☐ No

Who was cited: ☐ Self ☐ Other

In relation to your skull, the headrest was: ☐ Above ☐ Below ☐ At the base of skull

What did you impact? ☐ Another vehicle ☐ Other: _____

Any body parts struck the vehicle? _____

Make/model of the vehicle you were occupying? _____

Street name on which you were traveling? _____

You were heading: ☐ North ☐ West ☐ South ☐ East - At (speed) _____ MPH.

The impact came from the: ☐ Front ☐ Rear ☐ Lt Side ☐ Rt side

During the impact you were facing: ☐ North ☐ West ☐ South ☐ East

You were ☐ Aware of the impact before it occurred ☐ Surprised by the impact

What was the make/model of the other vehicle: _____

They were heading: ☐ North ☐ West ☐ South ☐ East At (speed) _____ MPH

Describe the accident in detail: _____

_____

_____

Were you rendered unconscious? ☐ No ☐ Yes, for (how long?) _____

Please describe how you felt after the accident: _____

Hospital? ☐ Yes ☐ No **Ambulance?** ☐ No ☐ Yes (where?) _____

When did you go? ☐ After the accident ☐ Next day ☐ 2+ days

Did you do any imaging? ☐ X-rays ☐ CT scans ☐ MRIs

TELL US ABOUT YOUR PAIN:

☐ **Dizziness**	☐ **Neck Pain / Stiffness**	☐ **Elbow Pain** __ L __ R
☐ **Memory Loss**	☐ **Chest Pain**	☐ **Wrist / Hand Pain** __ L __ R
☐ **Headaches**	☐ **Upper Back Pain**	☐ **Leg Pain** __ L __ R
☐ **Nausea**	☐ **Mid Back Pain**	☐ **Knee Pain** __ L __ R
☐ **Blurred Vision**	☐ **Lower Back Pain**	☐ **Foot / Ankle Pain** __ L __ R
☐ **Buzzing / Ringing in Ear(s)** __L __R		☐ **Numb Arm / Hands / Fingers** __ L __ R
☐ **Shoulder Pain** __ L __ R		☐ **Numb Legs / Feet** __ L __ R

☐ **Other:** _____

Employer: _____ **Occupation:**_____

Does your pain Interfere with: ☐ Work ☐ Sleep ☐ Daily Routine

Have you had a similar condition in the past? ☐ Yes ☐ No

Have you ever been treated by a medical physician before? ☐ Yes ☐ No

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No **Whom?** _____

Have you been able to work? ☐ Yes ☐ No **Number of hours in a workday?** _____

Has your work been affected since the accident? ☐ Yes ☐ No

While in recovery, is there light duty work you can request? ☐ Yes ☐ No

To evaluate the effect that continuing work will have on your recovery please complete:

☐ **Standing**	☐ **Driving**	☐ **Operate equipment**	☐ **Sitting**	☐ **Twisting**
☐ **Walking**	☐ **Crawling**	☐ **Work with arms**	☐ **Lifting**	☐ **Bending**
☐ **Stooping**	☐ **Other** _____			

Indicate your degree of comfort when performing the following activities:

Activity	Comfortable	Uncomfortable	Painful	N/A
Lying on the back	☐	☐	☐	☐
Lying on the side	☐	☐	☐	☐
Lying on the stomach	☐	☐	☐	☐
Sleeping sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Running	☐	☐	☐	☐
Sports	☐	☐	☐	☐
Working	☐	☐	☐	☐
Lifting	☐	☐	☐	☐

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: _____ DATE: _____

WITNESS: _____

Authorization For Medical Treatment

I, the undersigned, patient in this office hereby authorize **MULTI-CARE MEDICAL OF SW FLORIDA** and/or the physicians of **MULTI-CARE MEDICAL OF SW FLORIDA**(and whomever they designate as their assistants) to administer such treatments as is necessary and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.
I hereby certify that I have read and fully understand the above Authorization of Medical Treatment, the reason why the above named treatment is considered necessary, its advantages and possible complications, if any as well as possible alternative modes of treatment which are explained to me by **MULTI-CARE MEDICAL OF SW FLORIDA** and/or the physicians of **MULTI-CARE MEDICAL OF SW FLORIDA** .
I also certify that no guarantee or assurance has been made as to the result that may be obtained.

Patient Signature: _____ Date: _____

Patient Name: _____ Witness: _____

Authorization For Medical Information

The authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-Ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Florida “NO FAULT” auto insurance.

Patient Signature: _____ Date: _____

Authorization For Wage And Salary Information

The authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary. You are authorized to provide this information in accordance with the Florida “NO FAULT” auto insurance law (Chapter 71.252F.5)

Patient Signature: _____ Date: _____

Social Security #: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR FILES A STATEMENT OR CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Notice Of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: _____ Date: _____
Patient Name: _____ Witness: _____

IRREVOCABLE DEFERRED PAYMENT AGREEMENT

I _____, hereby authorize **Multi-Care Medical Of SW Florida, PLLC.** ("Provider") to defer, at its sole discretion. The demand for payment for services rendered. I understand that such a deferral may be granted, modified, or revoked at any time and for any reason. Notwithstanding any deferral, I acknowledge and agree that I remain **personally and fully responsible** for all charges and fees for services rendered to me by **Multi-Care Medical Of SW Florida, PLLC**. and/or its providers. This agreement is made solely to extend courtesy and flexibility in payment timing and does **NOT** release me from financial responsibility for said services. I further agree that, in the event of failure to pay the demanded amount when due, I shall be responsible for all reasonable attorney's fees, collection costs, and expenses incurred by **Multi-Care Medical Of SW Florida, PLLC.** in the enforcement of this agreement or collection of my outstanding balance. By signing below, I confirm that I have **read, understood, and voluntarily agreed** to the terms contained in this document.

Patient Name : _____

Signature: _____

Date: _____

Multi-Care Medical Of SW Florida
13701 Cypress Terrace Cir.
Fort Myers, FL 33907
Ph : (239)277-1655
Fx : (239)277-1255
Email: admin@multi-caremedical.com

AFFIDAVIT OF HEALTH INSURANCE

I acknowledge the following by initialing my selection:
PLEASE MAKE A SELECTION BELOW

_____I certify that I was not covered by any form of health insurance at the time of the accident that occurred on _____.

_____ I do have health insurance and Multi-Care Medical (MCM) is authorized to submit a claim on my behalf, however they are not in network providers for my health insurance.

_____I do have health insurance and elect not to use my health insurance for the following reason:

(CHECK ALL REASONS THAT APPLY TO YOU BELOW)

_____ The out-of-pocket, co-insurance, deductible and copays are a financial hardship for me.
_____ I have been unable to obtain the referrals/authorizations necessary for me to use my insurance plan and receive care in a timely manner
_____ I have not been able to find a doctor in my insurance network that will see me in a timely manner.
_____ Other:_____

I understand that I am financially responsible for medical services provided to me. I further understand that MCM is not contracted with any health insurance carriers and is under no obligation to bill or accept any form of insurance payment. The patient agrees that our rates are reasonable and customary based on the geographic location where the treatment was rendered. If requested, MCM may submit a claim to my insurance as a courtesy, but such submission does not create any agreement to accept the insurance rate as full payment.

SUBSCRIBED AND SWORN TO UNDER THE PAINS AND PENALTIES OF PERJURY ON THIS_____DAY _____OF _____ 2026.

Signed:_____ Date:_____
Multi-Care Medical is not in network, but we will bill for out of network when applicable. *

PRINTED NAME:_____

FORT MYERS
13701 Cypress Terrace Cir.
Fort Myers, FL 33907
239-277-1655

CAPE CORAL
1425 Viscaya Parkway, Suite 203
Cape Coral, FL 33990
239-236-5570

NAPLES
860 111th Ave North
Naples, FL 34108
239-228-3221

STAT REQUEST!

Date: _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information may be disclosed by: _____

Tel: _____ Fax: _____

Information to be disclosed to : **MULTI-CARE MEDICAL OF SW FLORIDA**

13701 CYPRESS TERRRACE CIRCLE. FORT MYERS, FL 33907

TEL: (239) 277-1655 FAX: (239) 277-1255

PATIENT WHOSE PROTECTED HEALTH INFORMATION IS TO BE DISCLOSED

Patient Name: _____ Date of Birth: _____

Social Security: _____ Date of Accident: _____

INFORMATION TO BE DISCLOSED

- ☐ ALL MEDICAL RECORDS
- ☐ Final Narrative Dictated Report
- ☐ Patient was involved in a prior MVA on or approximately: _____
- ☐ X-RAYS / MRI / CT / ULTRASOUND
- ☐ Progress Notes / Consultation
- ☐ Other: _____

Expiration Date – This authorization will expire (_____) 2 years from the above referenced date. I understand that if I fail to specify an expiration or event, this authorization will expire six (6) months from the date on which I signed.

Re-Disclosure: I understand that once the above information is disclosed. It may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing the authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Revocation: I understand that I have the right to revoke this authorization at any time by giving a written/verbal notice to the office listed above.

_____ _____

Patient Signature Date