

**Dr. Mark Saracino**  
Board Certified  
Chiropractic Neurologist

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(Please print and fill-out this form then bring it to the office, or fill-out online and email to: [mark.saracino1@juno.com](mailto:mark.saracino1@juno.com) or fax to 610 337 4858.)

Welcome. Every attempt will be made to make your visits pleasant and beneficial. This could be your first experience with a sub-specialist within chiropractic. If you have any questions, please feel free to ask. Chiropractic Neurology values good patient-doctor dialogue. Please complete this form; the information is important to aid in your prompt recovery.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ S.S.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ single{ } married{ } divorced{ } widowed{ }

**E-mail address** \_\_\_\_\_ number of children \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Describe your daily living/working activities \_\_\_\_\_

\_\_\_\_\_

Briefly describe your present ailment \_\_\_\_\_

Date you first noticed symptoms \_\_\_\_/\_\_\_\_/\_\_\_\_ How did they occur? \_\_\_\_\_

\_\_\_\_\_

Have you previously experienced similar symptoms? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever received manipulations from a physician? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_

For what condition? \_\_\_\_\_

Are you currently receiving treatment from a physician? \_\_\_\_\_

Doctor's name? \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Describe treatment and reason \_\_\_\_\_

Are you currently on medication? \_\_\_\_\_ Which and for what  
diagnosis? \_\_\_\_\_

List major surgeries and their dates \_\_\_\_\_

\_\_\_\_\_

Are you presently involved with a special diet, exercise or therapeutic plan? \_\_\_\_\_

Describe \_\_\_\_\_

\_\_\_\_\_

Special interests/hobbies/activities \_\_\_\_\_

Whom shall I thank for your referral? \_\_\_\_\_

Payment for services and products is required at the time performed or given, unless other arrangements have been made. When the doctor accepts assignment for your insurance contract, keep in mind that the contract is between you and your carrier only. Any denial of coverage that results in a reduced or nonpayment and leaves a balance to the doctor then becomes your responsibility to pay the doctor, within 15 days of written notification of denial by the insurance company or this office, whichever comes first. The balance due is then subject to an interest charge of 1.5% per month (18% per annum) on accounts more than 30 days past due, and will accrue from the date of service, not the billing date. An additional 20% attorney's fee will be included should your account be referred to an attorney for collection.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I acknowledge seeing the posted Receipt of Notice of Privacy Practices for Protected Health Information in Dr Saracino's waiting room.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_