SUNSHINE STATE MEDICAL INC

5425 S. Semoran Blvd Suite 6A, Orlando, FL 32822
Tel: 407-482-0052
Email: martha@ssmio.net
Website: ssmio.net

In case you need it, we also provide the following services:
Chiropractor - Internal Medicine - Physical Therapy - NCV/EMG - School/Sports Physicals - Disability - Auto Accidents Treatment - Workers Comp - Slip & Falls

Immigration Medical Exam Patient Form

Today's Date: _____ **Time:** _____

How did you hear about us? ☐Google ☐Radio ☐Patient Referral ☐Attorney Referral ☐Staff ☐ZocDoc ☐Website

First Name: _____ Middle: _____ Last Name: _____

Do you have an immigration appointment? ☐Yes ☐No If yes, please include date: _____

Please check the correct box for each item below: Check at least one box for each sign or symptom listed:

Bruising easily	☐Present	☐Past	☐Never	Swollen joints	☐Present	☐Past	☐Never	Stiff neck	☐Present	☐Past	☐Never
Liver problem	☐Present	☐Past	☐Never	Dizziness	☐Present	☐Past	☐Never	Ulcers	☐Present	☐Past	☐Never
Kidney infection	☐Present	☐Past	☐Never	Headache	☐Present	☐Past	☐Never	Chest Pain	☐Present	☐Past	☐Never
Painful urination	☐Present	☐Past	☐Never	Loss of weight	☐Present	☐Past	☐Never	Difficulty breathing	☐Present	☐Past	☐Never
Prostate trouble	☐Present	☐Past	☐Never	Asthma	☐Present	☐Past	☐Never	Chronic cough	☐Present	☐Past	☐Never
High blood press.	☐Present	☐Past	☐Never	Cancer	☐Present	☐Past	☐Never	Backache (Upper)	☐Present	☐Past	☐Never
Low blood press.	☐Present	☐Past	☐Never	Nose bleeds	☐Present	☐Past	☐Never	Backache (lower)	☐Present	☐Past	☐Never
Hearth Trouble	☐Present	☐Past	☐Never	Allergy	☐Present	☐Past	☐Never	Osteoporosis	☐Present	☐Past	☐Never
Stroke	☐Present	☐Past	☐Never	Diabetes (Type 1)	☐Present	☐Past	☐Never	Whiplash	☐Present	☐Past	☐Never
Spinal problem	☐Present	☐Past	☐Never	Diabetes (Type 2)	☐Present	☐Past	☐Never	Numbness (Arms)	☐Present	☐Past	☐Never
Arthritis	☐Present	☐Past	☐Never	Anemia	☐Present	☐Past	☐Never	Numbness (Legs)	☐Present	☐Past	☐Never
Thyroid problem	☐Present	☐Past	☐Never	Jaundice	☐Present	☐Past	☐Never	Weakness	☐Present	☐Past	☐Never

Have you ever had any operation/surgery ☐Yes ☐No

If yes, please list:

Date	**Procedure**	**Date**	**Procedure**
_____	_____	_____	_____
_____	_____	_____	_____

Please list any hospitalizations, and infectious diseases: _____

Are you presently taking any medications - prescriptions or over-the-counter ☐Yes ☐No

If, yes, What Drugs: _____

Have you ever had any of the following?

☐Syphilis ☐Gonorrhea ☐Tuberculosis ☐Red rash in your whole body

Do you currently have a primary care physician? ☐Yes ☐No

Do you have records of the required Vaccines?

☐MMR ☐TDAP ☐Varicella (Chickenpox) ☐Covid-19 ☐Influenza (flu) October – March

List any previous accident, fall or injuries and dates

Car	**Sport**	**Personal**	**Other**
_____	_____	_____	_____
_____	_____	_____	_____

Are you working with an immigration attorney? ☐Yes ☐No

If, yes, please include their contact info: _____

_____

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Do you have health Insurance ☐Yes ☐No If yes, name of Insurance: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

This office wishes to advise you that you have certain rights and privileges, as do we. In essence, they are:

1. You have the right to have your privacy protected. Your case will only be discussed between you, your doctor, insurance companies, and other third parties if you authorize us to do so.
2. You have the right to expect to be informed of the progress of your treatment, results of tests done, etc.
3. You have the right to request copies of your files to be sent to another facility, be it chiropractic, medical, osteopathic, or legal (a copy fee will be charged for this service).
4. Our right is to expect that you are factual with the information you provide on your forms, insurance forms, etc.
5. Our right is to expect that you will follow the treatment and ancillary procedures and regimens suggested by the doctor.
6. Our right is to expect prompt payment for services rendered.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of medical/chiropractic health care, and I give authority for these procedures to be performed and billed directly to my medical/chiropractic insurance. I understand that my medical/chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

_____ _____

Patient Signature (or signature of parent or legal guardian if patient is a minor) **Date**

For Women Only

By signing below, I certify that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for the procedure. In so doing, I release the doctor / clinic from responsibility for potential damage arising from this procedure.

At the present time:
- ☐ I am sure I am not pregnant
- ☐ It is possible that I could be pregnant
- ☐ I am pregnant

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