Welcome to Our Office

How did you hear about us? Friend Phone Book Physician Other

Reason for Visit: ____Accident ____ Work Injury ____Sports Injury ____ Recurring Illness ____ Post-Surgery

PATIENT
Last Name:_________________________________First:________________________M.I._______
Street Address: ____________________________________ City: State:
Zip : Date Of Birth:___/____/___Sex:(M/F)________S.S.#: - -
Home Phone:_________________ Work Phone:_______________ Cell:_________________
Email:______________________________________

DRIVERS LICENSE AND INSURANCE CARD (*GIVE TO RECEPTIONIST TO COPY*)
1. Are you Employed ? YES NO Are you a student? YES NO If yes___ full time ____part time
2. Marital Status: _______Single _____Married ______ Other
3. Today's Date ____/___/___
4. Doctor who referred you to this Clinic:____

EMPLOYER (or parents if under 18 years of age)
Name of Company:____ Work Number:______________
Address:____City:________________State:____

EMERGENCY CONTACT (Friend or Relative not living with you)
Name of Contact: _________________________Phone/Cell/Beeper: (___)___________Relationship:___________

INSURANCE INFORMATION (give insurance card to receptionist)
Primary Insurance: ID# or Policy#
Mailing Address: City: _______________State ______Zip
Name of Insured: _____________________________Group name: ___________________Group #

SECONDARY INSURANCE INFORMATION (give insurance card to receptionist)
Secondary Insurance: ID or Policy#
Mailing Address: City____________________State_______Zip
Name of insured: _____________________________Group Name or #

WORKER'S COMPENSATION
Comp.Carrier: Phone:
Address: City_____________________State Zip
Adjuster:____ Verified By:
Date of Accident:__________________ Claim Number:

ATTORNEY INFORMATION
Attorney Name:______________________________________Phone______________________
Address:____City____________________State_________Zip

HAVE YOU RECEIVED CHIROPRACTIC, PHYSICAL THERAPY THIS YEAR? Yes/No

How long was your treatment? ____

YOUR MEDICAL HISTORY

PLEASE MARK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

___ Heart Attacks	___ Allergies	___ Asthma
___ Angina	___ Osteoporosis	___ Fracture
___ Stroke	___ Emotional Problems	___ Whiplash
___ Tumors	___ Nervous Problems	___ Lung Disease
___ Cancer	___ Kidney/Bladder Disease	___ Hernia
___ Diabetes	___ Back Injury	___ Gout
___ Epilepsy/Convulsions	___ Neck Injury	___ Dislocations
___ Arthritis	___ Hepatitis	___ Thyroid Disease
___ Circulatory Problems	___ Tuberculosis	___ Joint Strain
___Respiratory Problems(COPD)	___ Pneumonia/Emphysema	___ Muscle Strain
___Gastrointestinal Disease	___ High Blood Pressure	___TMJ
___Alcohol Problem	___ Congestive Heart Failure	___ Pacemaker
___ Valvular Disease	___ Atherosclerotic Diesase	___ Pregnant Now
___ Surgical Implants	___ Congenital Disorders	___Dementia/Alzheimers

MARK THE FOLLOWING IF YOU HAVE RECENTLY EXPERIENCED:

___ Headaches	____ Shortness of Breath	___ Hoarseness
___ Muscular Pain w/exertion	____ Weight Loss	___ Falls
___ Dizziness	___ Tingling, Numbness	___ Tremors
___ Balance Problems	___ Muscle Pain at Rest	___ Fatigue
___ Pain Coughing Sneezing	___ Difficulty Sleeping	___ Weakness
___ Blurred Vision	___ Skin Discoloration	

___ Constant Pain Unrelieved By Rest Movement

PLEASE LIST ANY MAJOR SURGERIES OR HOSPITALIZATIONS:

____
____

PLEASE LIST IF YOU ARE ALLERGIC TO ANY MEDICATIONS

____
____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

____
____

PLEASE MARK THE FOLLOWING DIAGNOSTIC TEST YOU HAVE TAKEN

___X-RAY OF ________________________DATE_____RESULTS_____________________
___MRI OF __________________________ DATE_____RESULTS_____________________
___EMG/NCV OF ____________________ DATE_____RESULTS_____________________

PLEASE MARK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN

___CONSTANT	___INCREASING	____NIGHT PAIN	___STIFFNESS
___DULL/ACHY	___INTERMITTENT	___ DECREASING	___SHARP PAIN
___OCCASIONAL	___ STATIC	___ PAIN UPON WAKING	

PATIENT NAME:____DATE _______________

CONSENT FOR TREATMENT: I as a patient consent to treatment by Fernando Rey, DC. I consent to maintain the confidentiality of the other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than me.

Patient Signature: ____Date: _________________

AUTHORIZED RELEASE OF INFORMATION: I hereby authorize Fernando Rey, DC to release medical records pertaining to my treatment to any entity that is responsible for payment of treatment charges. I understand that this authorizes my insurance company to pay any benefits directly to Fernando Rey, DC. In addition, I further understand that I am ultimately responsible for any remaining co-insurance or co-payment.

Patient
Signature:____Date:_________________

HIPPA Patient Information Consent: I have read and fully understand Fernando Rey, D.C.'s Notice of Information Practices. I understand that Fernando Rey, DC. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Fernando Rey, DC. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal information for purposes as noted in Fernando Rey, DC. Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient
Signature: ____Date_________________