Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separeted ☐ Divorced

Patient employed by _____ Occupation _____

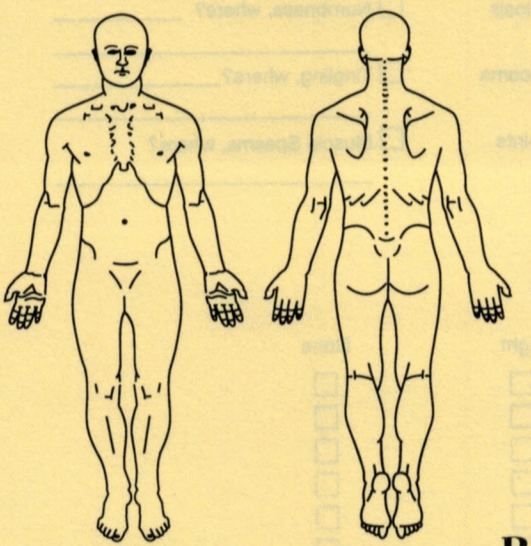
Business Phone _____ Business Email _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Please mark on the diagram the location of the pain.



- Current pain: /10 0 1 2 3 4 5 6 7 8 9 10
- Average pain: /10 0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL DURING:

- Activities of Daily Living: /10 0 1 2 3 4 5 6 7 8 9 10
- Work: /10 0 1 2 3 4 5 6 7 8 9 10
- Sports/Recreation: /10 0 1 2 3 4 5 6 7 8 9 10

When and what makes it better? _____

When and what makes it worse? _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for this visit _____

Please describe your current pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pani? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perfom: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping

☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination, diagnostic x-rays and physical therapy techniques, on me (of on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licenses doctors of Chiropractic who now, or in the future, render treatment to me while employed by, working for, or associated with, or serving as back up for the doctor of Chiropractic named below.

I understand that as with any health care procedures, there are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to; fractures, disk injuries or dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then, known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the natural purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the Chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Name(s) of Doctor(s) Treating Patient:

James Baranski, D.C.
Advanced Spine & Sport Chiropractic
4601 Telephone Rd., Suite 110
Ventura, CA 93003
(805) 642-4061

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient Date

_____ _____

Witness to Patient's Signature Date

_____ _____

Translated By Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay _____ as well as all employees, employers, representatives, and agents thereof, (collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, test, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any heath status, conditions, symptoms, or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoke in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____20_____ .

_____

(Patients signature)

_____

(Please print patient name)

_____

(Signature of Guardian if Applicable)

Privacy Practices Acknowledgement

I have been given the opportunity to review the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Advanced Spine & Sport Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

_____

Printed Name of Patient

_____ _____

Patient Signature Date

Medical Release of Information to PCP/Ortho

It is our intention to communicate with your primary care physician or other providers providing you service for your medical conditions from time to time to keep them posted on your care being provided in our office. This is an effort to maintain the highest quality of care for you and your family.

I hereby authorize the provider to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. Should you not want us to communicate with them please indicate by checking the appropriate box below.

[ ] We are welcome to communicate with my PCP and other healthcare providers taking care of me.
[ ] I would prefer you not to communicate with my PCP and other health care providers that take care of me.

I, _____ have read and fully understand the above statements.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Physician Names

1. _____
2. _____
3. _____

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls		
Head injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing? ☐ Y ☐ N

Medical Conditions

Have you ever had or do you currentiy have any of the following medical conditions?

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. if there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.