# Axis Chiropractic & Rehab

## -PATIENT RECORD-

NAME_____

STREET ADDRESS_____

CITY / STATE / ZIP_____

HOME PHONE_____ WORK PHONE_____

EMPLOYER / OCCUPATION_____

Date Of Birth_____ Social Security Number_____

Drivers License #_____ E-mail_____

Marital Status (Check) ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name_____ Employer / Occupation_____

Children_____Age_____ Name of Nearest Relative_____Phone_____

Patients Statement of Problem:_____

_____

What is condition related to: (Check) ☐ Employment ☐ Auto Accident ☐ Other_____

Date condition / accident began_____ Was it gradual? (Check) ☐ Yes ☐ No

Have you ever had same or similar symptoms? (Check) ☐ Yes ☐ No, Describe_____

Lost Work Time (Check) ☐ Yes ☐ No If yes, date you returned to work_____

Were you referred by another physician? (Check) ☐ Yes ☐ No, Describe_____

Have you seen another doctor for this condition? (Check) ☐ Yes ☐ No, List

_____

_____

Have you seen a chiropractor for this condition? (Check) ☐ Yes ☐ No

What medications or drugs are you taking?_____

_____

List all surgeries that you have had_____

_____

Are you pregnant?_____

Referred by: ☐ Yellow Pages (Specify_____) ☐ Sign ☐ Mailer

☐ Friend_____ ☐ Other_____ ☐ Preferred Provider Book

Insurance Information (Check) ☐ No Insurance ☐ Medicare

☐ Major Medical ☐ Group Health ☐ Personal Injury (Auto Accident)

☐ Workman's Compensation (On The Job Injury)

I understand and agree to authorize AXIS CHIROPRACTIC and all employees to administer whatever examination procedures and treatments as they deem necessary.

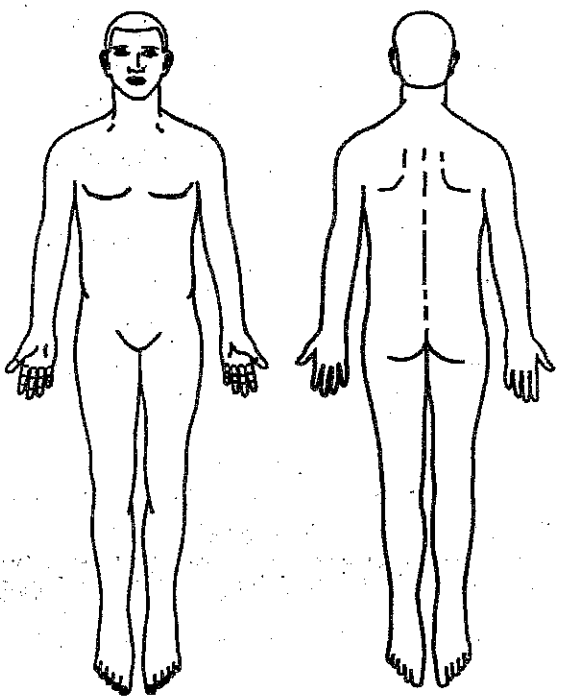
**Patient's Signature**_____Date_____

Guardian or Spouse's Signature

**Authorizing Care**_____Date_____

**IF THIS IS RELATED TO AN AUTO ACCIDENT OR WORK INJURY, PLEASE FILL OUT REVERSE SIDE.**

**PLEASE MARK ALL AREAS OF PAIN**
**BE SPECIFIC**



**FRONT** **BACK**

## IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident_____ Hour_____ ☐ AM ☐ PM; Location_____

How did the accident occur? ☐ Auto Collision ☐ On-The-Job Injury ☐ Other_____

Please describe the Accident or Injury_____

_____

_____

**Work Related Information:**

Did you report the injury to your Foreman or Employer? ☐ Yes ☐ No

Give name and phone number of foreman or authorized person_____

Name and number of where you work_____

Address of company_____

**Auto Accident Information:**

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian

Were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

Did your car strike the other(s) involved? ☐ Yes ☐ No ☐ Undetermined

Were you using a seat belt? ☐ Yes ☐ No A shoulder belt? ☐ Yes ☐ No

Was your head turned at impact? ☐ Yes ☐ No; ☐ Right ☐ Left

Were you aware of the approaching collision prior to impact or were you caught by surprise? ☐ Aware ☐ Surprise

Road conditions? ☐ Wet ☐ Dry ☐ Icy ☐ Other_____

**Injuries:**

List the extent of the injuries (or pains) as you know them:_____

Did you require post-accident hospitalization? ☐ Yes ☐ No; Were you taken by Ambulance? ☐ Yes ☐ No

Were you treated in the Emergency Room? ☐ Yes ☐ No, Describe_____

_____

## CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

| | | | |
|---|---|---|---|
| ☐ Headache | ☐ Neck Pain | ☐ Shortness of Breath | ☐ Numbness in Toes |
| ☐ Irritability | ☐ Chest pain | ☐ Buzzing in Ears | ☐ Numbness in Fingers |
| ☐ Dizziness | ☐ Back Pain | ☐ Ears Ring | ☐ Pins & Needles in Arms |
| ☐ Fainting | ☐ Neck Stiffness | ☐ Sleeping Problems | ☐ Pins & Needles in Legs |
| ☐ Fatigue | ☐ Cold Sweats | ☐ Lights Bother Eyes | ☐ Loss of Balance |
| ☐ Nervousness | ☐ Hands Cold | ☐ Stomach Upset | ☐ Loss of Memory |
| ☐ Depression | ☐ Feet Cold | ☐ Constipation | ☐ Loss of Smell |
| ☐ Tension | ☐ Face Flushed | ☐ Diarrhea | ☐ Loss of Taste |
| ☐ Fever | ☐ Head seems to Heavy | | |

Symptoms other than above_____

_____

Have you had similar accidents or injuries before? ☐ Yes ☐ No, When?_____

Have you lost any days of work? ☐ Yes ☐ No, Dates:_____

## INSURANCE OR ATTORNEY INFORMATION:

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No If Yes, Name_____

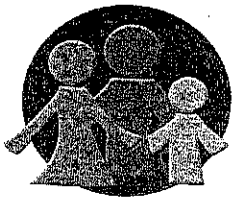
Address_____ Telephone_____

Are you covered by Personal Injury Protection on your car insurance? ☐ Yes ☐ No

Your insurance company name_____ Telephone_____

Responsible parties insurance company_____ Telephone_____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No,



# AXIS CHIROPRACTIC

IF YOU OR ANY MEMBER OF YOUR FAMILY HAVE EXPERIENCED ANY OF THE FOLLOWING PLEASE CHECK IT OFF IN THE APPROPRIATE SPACE.

| CONDITION | SELF | SPOUSE | MOTHER | FATHER | CHILD 1 | CHILD 2 | CHILD 3 |
|---|---|---|---|---|---|---|---|
| HEADACHES | | | | | | | |
| SINUS TROUBLE | | | | | | | |
| ALLERGIES | | | | | | | |
| EYE TROUBLES | | | | | | | |
| EARACHES | | | | | | | |
| HEARING DYSFUNCTION | | | | | | | |
| SKIN DISORDERS | | | | | | | |
| THROAT PROBLEMS | | | | | | | |
| NECK OR SHOULDER PAIN | | | | | | | |
| TONSILLITIS | | | | | | | |
| FREQUENT COLDS | | | | | | | |
| BURSITIS | | | | | | | |
| THYROID DISORDERS | | | | | | | |
| ASTHMA | | | | | | | |
| BREATHING PROBLEMS | | | | | | | |
| PAIN IN ARMS OR HANDS | | | | | | | |
| HEART DYSFUNCTION | | | | | | | |
| CHEST PAIN | | | | | | | |
| GALL BLADDER PROBLEMS | | | | | | | |
| SHINGLES | | | | | | | |
| LIVER PROBLEMS | | | | | | | |
| ANEMIA | | | | | | | |
| STOMACH DISORDERS | | | | | | | |
| DIABETES | | | | | | | |
| DIGESTIVE PROBLEMS | | | | | | | |
| COLITIS | | | | | | | |
| HERNIA | | | | | | | |
| APPENDICITIS | | | | | | | |
| MENSTRUAL DISORDERS | | | | | | | |
| IMPOTENCY | | | | | | | |
| URINARY TRACT PROBLEMS | | | | | | | |
| BACKACHE | | | | | | | |
| LEG WEAKNESS OR CRAMPS | | | | | | | |
| HEMORRHOIDS | | | | | | | |
| KNEE PROBLEMS | | | | | | | |
| FOOT OR ANKLE PROBLEMS | | | | | | | |

# AUTHORIZATION, ASSIGNMENT, CONSENT TO TREAT AND POWER OF ATTORNEY

In consideration of your undertaking to treat me, I agree to the following:

## Medical Release

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

## Assignment of Benefits

I authorize and instruct my attorneys and/or insurance company to make direct payment to you in your name only of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my claim, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign any action I may have against such company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

## Power of Attorney

I, the undersigned, do hereby appoint Moya Chiropractic LLC. and any of it's duly authorized agents to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with Moya Chiropractic LLC. when said payments are due for services rendered on behalf of the undersigned by the clinic.

## Authorization to Treat

I, the undersigned, hereby authorize Moya Chiropractic LLC., (and whomever may be designated as assistants) to administer such examinations and treatment as they deem necessary.

A photocopy of this assignment shall be valid and have the same effect as the original.

DATE PATIENT SIGNATURE WITNESS

# MOYA CHIROPRACTIC, LLC.

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Moya Chiropractic LLC. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Moya Chiropractic's LLC. Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Moya Chiropractic LLC. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Moya Chiropractic LLC. Privacy Officer at 24165 IH-10W, Suite 106, San Antonio, TX 78257.

With this consent, Moya Chiropractic LLC. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including diagnostic test results among others.

With this consent, Moya Chiropractic LLC., mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are addressed to me personally.

With this consent, Moya Chiropractic LLC. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Moya Chiropractic LLC. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to MOYA CHIROPRACTIC's LLC. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, MOYA CHIROPRACTIC LLC. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date