Chiro TM CONFIDENTIAL PATIENT INFORMATION

Name: Mr. Mrs. Ms. (circle one) _____ (Last) _____ (First) _____ (MI) **Date:** ____/____/____

Have you been treated at our clinic before?

☐ **NO** If NO. Please complete ***ALL*** sections on this form

☐ **YES** If YES. Please update any ***changed*** information in Sections A & B below. then complete Section C

SECTION A: Patient's Personal Information

Address: _____ (No. and Street) _____ (City and State) _____ (Zip)

Phone: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Emergency Contact: Home: _____ Work: _____ Cell: _____

Patient's DOB: ____/____/____ Age: _____ Male / Female SS# _____-____-_____

Marital Status: (circle one) Married Single Divorced Separated Widowed No. of children? _____

Occupation: _____ ☐ Full-Time ☐ Part-Time

Employer: _____ Address: _____

How did you hear about our office? _____

How will you be paying for your portion of today's visit: ☐ **CASH** ☐ **CHARGE** ☐ **CHECK**

SECTION B: Insurance Information

We will gladly file insurance for our patients. Our policy is to collect full payment at time of service until coverage is verified

Are you covered by medical insurance? ☐ **YES** ☐ **NO**

Name of primary insurance _____ Group or ID# _____

Are you covered by secondary insurance? ☐ **YES** ☐ **NO**

Name of secondary insurance _____ Group or ID# _____

Insured/Policy Holder's Information *If the patient IS the insured, please just check* SAME

Relationship to patient: ☐ SAME ☐ Spouse ☐ Parent ☐ Other (explain): _____

Insured's Name: _____ Address: _____

Phone: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Insured's DOB: ____/____/____ Age: _____ SS# _____-_____-_____

Employer: _____ Address: _____

PLEASE PRESENT YOUR HEALTH INSURANCE CARD TO FRONT DESK

SECTION C: Accident/Injury Information

Is today's visit due to an accident or injury? ☐ **YES** (Please fill out Section C completely) ☐ **NO** (Skip this Section)

☐ **WORK ACCIDENT** Date of Accident: ____/____/____ Time of Accident : _____ AM / PM

Did you report accident to your Supervisor: ☐ **YES** ☐ **NO** Name: _____

☐ **AUTO ACCIDENT** Was a police report filed? ☐ **YES** ☐ **NO** Do you have an attorney? ☐ **YES** ☐ **NO**

Did you notify insurance agent? ☐ **YES** ☐ **NO** Agent's name & phone: _____

PLEASE PRESENT YOUR AUTO INSURANCE CARD AND A COPY OF POLICE REPORT if available.

Chiro™ PAST MEDICAL HISTORY

Patient Name: _____ **Date:** ____/____/____

If you are a male patient: When was your last prostate and rectal exam? _____

If you are a female patient: When was your last pap and breast exam? _____

Please place a "C" next to all symptoms or conditions you CURRENTLY have, and a "P" next to all that you have had in the PAST:

___ Abdominal pain
___ Abnormal weight gain
___ Abnormal weight loss
___ Alcoholism
___ Allergies (seasonal)
___ Anemia
___ Angina
___ Anorexia
___ Appendicitis
___ Arteriosclerosis
___ Arthritis
___ Asthma
___ Bladder Infection
___ Bleeding disorders
___ Blindness
___ Blurred vision
___ Breast soreness/lumps
___ Bulimia
___ Cataracts
___ Chemical Dependency
___ Chicken Pox
___ Chronic lung disease
___ Cold feet
___ Colitis
___ Congestive heart failure
___ Connective tissue disease
___ Constipation
___ Convulsions
___ Cough, chronic
___ Deafness or reduced hearing
___ Depression
___ Dermatitis/Eczema/Rash
___ Diabetes: Type I / Type II
___ Difficulty swallowing
___ Digestive problems
___ Dizziness
___ Ear ringing/buzzing
___ Emphysema
___ Endometriosis
___ Epilepsy
___ Excessive Thirst
___ Fainting
___ Fatigue
___ Fibromyalgia
___ Foot/ankle pain
___ Fractures
___ Frequent Urination
___ Gall Bladder Problems
___ Glaucoma
___ Goiter
___ Heart attacks
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herniated disc
___ Herpes
___ High Blood Pressure
___ High Cholesterol
___ Hip pain
___ Hormone replacement
___ HIV/AIDS
___ Hypertension
___ Indigestion/heartburn
___ Irregular menstrual flow
___ Irritable bowel/colon
___ Jaw pain/problems
___ Joint swelling/stiffness
___ Kidney Disease
___ Kidney Stones
___ Knee or lower leg pain
___ Liver Disease
___ Loss of appetite
___ Loss of bladder control
___ Loss of smell
___ Loss of memory
___ Loss of taste
___ Low Blood Pressure
___ Low Blood Sugar
___ Low back pain
___ Measles
___ Menopause
___ Menstrual cramps
___ Migraines
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Muscular incoordination
___ Nausea
___ Neck pain
___ Nervousness
___ Pacemaker
___ Painful urination
___ Parkinson's Disease
___ Pinched nerve
___ PMS
___ Pneumonia
___ Polio
___ Pregnancy
___ Prostate Disease
___ Prosthesis
___ Psychiatric Care
___ Psoriasis
___ Rapid heart beat
___ Rheumatic fever
___ Rheumatoid arthritis
___ Scarlet fever
___ Sciatica
___ Scoliosis
___ Shortness of breath
___ Sinusitis
___ Sleeping difficulties
___ SLE (Lupus)
___ Spinal Disc Disorder
___ STDs (venereal, etc.)
___ Stomach problems
___ Stroke
___ Tendonitis
___ Tension
___ Thyroid Disorder
___ Tumor(s)
___ Ulcer/GI bleeding
___ Upper arm/elbow pain
___ Upper back pain
___ Vaginal infections
___ Visual Disturbances
___ Whooping cough
___ Wrist pain

Please list any significant past injuries below:

Injury: _____ Date: ____/____/____ Describe Incident: _____

Injury: _____ Date: ____/____/____ Describe Incident: _____

Injury: _____ Date: ____/____/____ Describe Incident: _____

Please list any past surgical procedures and/or hospitalizations: _____

_____

FAMILY HEALTH HISTORY (Please include only parents, grandparents, and siblings.)

	Cancer	Connective Tissue Disease	Diabetes	Heart Disease	High Blood Pressure	Scoliosis	Stroke	Other:
Father's side								
Mother's side								
Siblings								

Please list any prescription, over-the counter medications or nutritional supplements you are currently taking:

Product	Reason for taking	Product	Reason for taking
1.		4.	
2.		5.	
3.		6.	

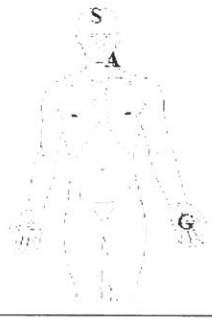
Patient's Signature _____

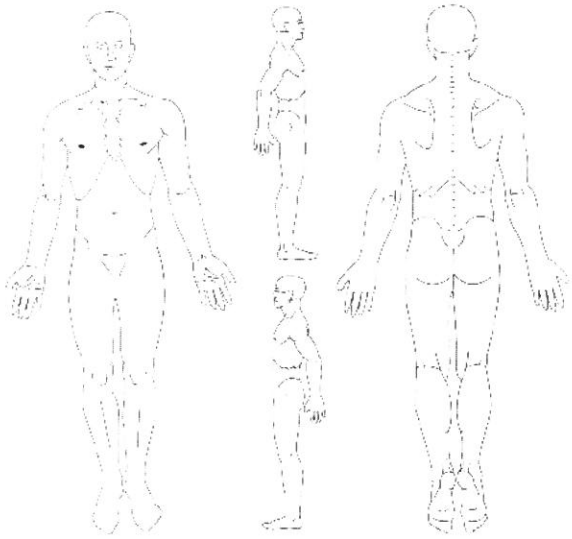
PAIN DIAGRAM

Name: _____ Date: ____/____/_____

On the diagram below, please indicate where you are experiencing pain or other symptoms by placing the corresponding letter for the type of pain you are having in that area.

Example:





Rate your pain frequency:

- ☐ Constant 75 – 100%
- ☐ Frequent 50 – 75%
- ☐ Occasional 25 – 50%
- ☐ Intermittent 25% or less

PAIN TYPES: A = ACHE B = BURNING W = WEAKNESS S = SHARP T = TINGLING F = STIFFNESS N = NUMBNESS

On each of the scales below, please draw a vertical line representing your pain or discomfort:

Example: 0 ——— 10
No Pain Unbearable Pain

Rate the pain you have right **now**:

0 1 2 3 4 5 6 7 8 9 10

Rate your pain at its **best** in the past week:

0 1 2 3 4 5 6 7 8 9 10

Rate your **average** pain in the past week:

0 1 2 3 4 5 6 7 8 9 10

Rate your **worst** pain in the past week:

0 1 2 3 4 5 6 7 8 9 10

Rate the pain you have while at **rest**:

0 1 2 3 4 5 6 7 8 9 10

Rate the pain you have with **activity**:

0 1 2 3 4 5 6 7 8 9 10

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA. Vol. 37 No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

Patient's Name Printed	Today's Date
Patient's Signature	Parent or Guardian Signature For Minor

Dr. David Cavazos DC, LLC
Chiropractic and Physical Therapy Center
66 E North Ave, Carol Stream IL 60188
P 630 915 3600 F 630 690 1005

Universal Consent Form

Patient Name: _____

Consent For Treatment

It is my wish to be treated by Dr. David Cavazos, DC, LLC and associates. I give permisssion for DDCDC,LLC physicians, physician assistants, chiropractic physicians and clinical employees caring for me to treat me in ways they judge will be beneficial. I further consent to any medication examinations, X-rays, tests or minor procedures that DDCDC,LLC physician determines to be necessary, I understand DDCDC,LLC physician will explain to me that nature of my condition, his/her recommended treatment and any associated risks involved. I also understand he/she will explain to me other ways this condition could be treated. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in this facility.

Acknowledgement of Receipt of Privacy Notice

I have been given an explanation of DDCDC,LLC "HIPAA Notice of Privacy Practices" and understand that I may call DDCDC,LLC Privacy Official if I have any questions regarding the content of this notice. I further understand that my medical record is considered privileged information and, as such, is protected by the State and Federal laws. DDCDC,LLC may use my information for purposes of treatment, payment and its operations as described in the notice of privacy practices.

I understand that, except as regulated by law, my medical record information will not be released should I refuse to sign this form. Therefore, I may be financially responsible for all costs incurred by me for treatment if a revocation or refusal to disclose information results in payment denial of my insurance claim.

Assignment of Benefits and Guarantee of Payment

I hereby authorize payment to Dr. David Cavazos, DC, LLC and its physicians (who agree to accept this assignment) and assign all of my rights and claims for reimbursement of expenses allowable under Medicare, Medicaid, Workers compensation, or any other health plans under which I may be entitled to reimbursement, I understand that I am financially responsible to DDCDC,LLC for charges not covered by my insurance and this assignment, allows authorzation to endorse your name on medical payment checks..

In consideration of medical services provided by DDCDC,LLC to the above-identified patient, I agree to pay to DDCDC,LLC all applicable fees and charges. In the event that this obligation remains unpaid and requires referral for collection, I agree to pay all costs of collection and/or reasonable attorney fees, I hereby authorize my attorney to pay DDCDC,LLC any outstanding balances due immediately upon receipt of any Workers' Compensation and/or Third Party Insurance Case settlement.

Medicare Certification and Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I have provided, as appropriate, the information related to Medicare as a secondary payer as it applies to my Medicare health care insurance.

X _____
Initials of Guarantor/Patient

Sharing of Medical Information: I hereby authorize DDCDC,LLC to share my registration, medical history, billing, insurance information, etc. within its own network. The sharing of information should avoid having you complete an identical form a second time and allow our staff to pre-approve tests or procedures more quickly, therby expediting your medical care when utilizing other service within DDCDC,LLC.

X _____
Initials of Guarantor/Patient

I have read and understand the above information and agree to its content:

_____ _____
Signature (Patient/Parent/Legal Guardian) Date

_____ _____
Signature of Guarantor (if other than above) Date

_____ _____
Signature of Witness Date

SPECIALIZED RADIOLOGY CONSULTANTS

1039 COLLEGE AVE., SUITE A WHEATON, IL 60187 (630) 462-9772

In an effort to provide you with the highest quality health care, it is the policy of your doctor's office to have the x-rays taken in his/her office read by a board-certified radiologist. This will be a separate charge from any of the clinics charges for the examination and taking of the x-rays. You will be billed separately for this service from this office. If you have insurance it will be billed first before asking you for any payment.

I, (Please Print) _____ consent to Specialized Radiology Consultants ("SRC") use and disclosure of my Protected Health Information for the purpose of providing radiology readings on me, for purposes relating to the payment of services rendered to me, and for SRC's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management, and other general operation activities. I understand that the SRC's diagnosis of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, **"Protected Health Information"** means any information, including my demographic information, created or received by SRC, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of SRC, but SRC is not required to agree to these restrictions. However, if SRC agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the SRC's Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I understand that if I desire a copy, I may call the above number and one will be copied and mailed to me.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or SRC has acted in reliance on this consent.

I understand that there will be a separate bill for SRC's radiology interpretation and written report. I also authorize all claims to be sent directly to the insurance company and I authorize payment to be made directly to SRC and accept responsibility for any remaining balance billed.

_____

Name of Patient (Please Print)

_____

Signature of Patient/ or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date