Registration

Date ________________

Email Address ________________
Cell Phone ________________
Work Phone ________________

Patient Name (Last, First Middle Initial) ____
Street Address ________________________________ **City** ___________ **State** ___________ **Zip** ___________
Sex M F Age ___________ **Birthdate (MM/DD/YYYY)** ________________ **Social Security # (last** 4) _____________
Single Married Widowed Separated Divorced
Driver's License # ________________________________
Insured's Name (Last, First) ____**Relationship to Insured: Self**
Condition Related to Illness Employment Auto Other **Spouse Child Other**

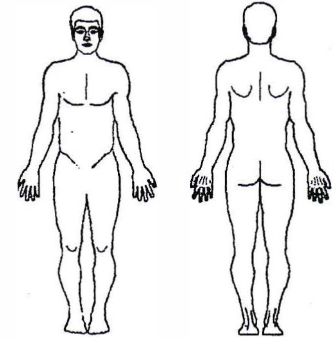
EMPLOYER	**Company Name** ____ **Occupation** ____________________________ **Address** ____________________________ **Phone** ______________ **City** __________ **State** __________ **Zip** __________
SPOUSE	**Name (Last, First Middle Initial)** ____ **Birthdate** ____________________________ **Social Security #** ______________ **Employer Name** ____________________________ **Occupation** ____________________________ **Address** ____________________________ **Phone** ______________ **City** __________ **State** __________ **Zip** __________
PATIENT INSURANCE INFORMATION	**Please any and all insurance coverage you or your spouse has applicable in this case.** **MEDICARE BLUE SHIELD AUTO ACCIDENT** **MEDICAID MAJOR MEDICAL UNION PLAN** **BLUE CROSS WORKER'S COMPENSATION OTHER** **BCBS I.D. #** _ _ _ _ _ _ _ _ _ _ **MEDICARE/MEDICAID I.D. #** _ _ _ _ _ _ _ _ _ _ _ **MAJOR MEDICAL OR AUTO INSURANCE Date of Accident** ______________ **Insurance Company Name** ____ **Adjuster** ____________________________ **Claim #** ______________ **Address/Phone** ____ **Policy #** ____________________________ **Effective Date** ______________
SPOUSE CO-INSURANCE INFORMATION	**MAJOR MEDICAL ONLY** **Insurance Company Name** ____ **Address/Phone** ____ **Policy #** ____________________________ **Effective Date** ______________
MEDICAL & LEGAL INFORMATION	**Referred by** ______________________________________ **Attorney** ____________________________ **Present Complaint** __________________________________ **Address**____________________________ **Known Medical Problems** ____________________________ **Phone** ______________ **Pregnant Yes No Pacemaker Yes No** **Family Physician (Name and Phone #)** ____ **Person to contact in emergency (Name and Phone #)** ____
PATIENT AGREEMENT	**ASSIGNMENT AND RELEASE** **I, the undersigned, have insurance coverage with** ______________________________________ **and assign** Name of Insurance Company **directly to Dr. Javier V. Suarez all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize this signature on all my insurance submissions.** ______________________________________ ______________ Signature of Insured/Guardian Date

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name______________________________ Birthdate__________________ Sex: M / F
Address______________________________ City______________________________
State______ Zip____________ Phone (____)____________ Patient Primary Language______________
Occupation__________________ Employer______________________ Work Phone______________
Address______________________ City______________________ State________ Zip__________
Subscriber Name______________________________ Health Plan______________________________
Subscriber ID #__________________ Group #________________ Spouse Name____________________
Spouse Employer____________________ City______________________ State________ Zip__________
Primary Care Physician Name______________________________ PCP Phone______________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

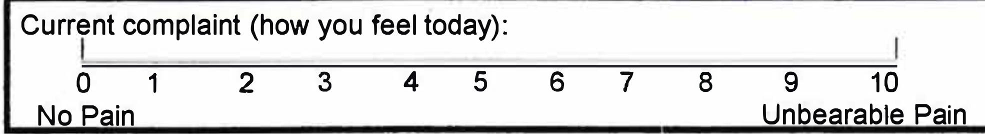
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other______________________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began______________________________

How Problem Began

Current complaint (how you feel today):



0 1 2 3 4 5 6 7 8 9 10
No Pain — Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken____________________ **What areas were taken?**____________________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)____________________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)________________
____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)____________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks____________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries______________________
____
☐ Tobacco Use - Type__________________
Frequency______________________/Day
☐ Medications______________________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature______________________________ **Date**____________________

Informed Consent for chiropractic Treatment of you Pain

By signing this form, your are consenting to an examination and/ or treatment with Javier Suarez, D.C., 114 S. Buena Vista St., Burbank California.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to manipulate the area treated. You may feel or hear a “click” or “pop” and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs or electrical stimulation. Your chiropractor will recommend treatment he/she determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and most patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not inherent risk of chiropractic treatment. Many variables can adversely affect one’s health including pervious injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous injury.

Other options for the treatment of pain include: do nothing – live with it, over-the-counter medications, physical therapy, medical car, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment and may use the space below for this purpose.

____

____

As in any health care procedure there are possible risks to treatment. Your chiropractor will rely on his/her judgment during the course of treatment, based upon the facts then known. We encourage you to ask your chiropractor and questions regarding your condition and treatment. Accepting you as patient does not guarantee relief or cure.

I ___________________ have read the above statements and hereby give my consent to treatment.

__________________________________ Signature (Patient/ Responsible Party)	_____________________________ Date
____________________________________ Witness	
____________________________________ Second Signature (review with Chiropractor)	_____________________________ Date

APPLICATION FOR TREATMENT

Please check the type of care desired: ☐ Temporary Relief ☐ Lasting Correction

☐ Check here if you want the Doctor to recommend the best type of care for you.

Date: ____________________

Name: ______________________________ Date of Birth: ____________________

Address: ______________________ City __________ State ____ Zip Code __________

Home Phone Number: ____________________ Phone at Work: ____________________

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Husband or Wife: ____________________ Ages of Children: ____________________

Where are you or husband/wife employed? ______________________________

Your days off: ____________________ Referred to our office by: ____________________

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other __________

How Payment will be made:

__________ Cash

__________ Check

Type of Insurance

__________ Workers' Comp.

__________ Credit Card

__________ Health Insurance

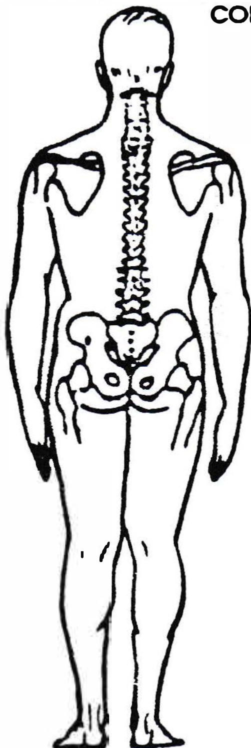
__________ Automobile Ins. Policy

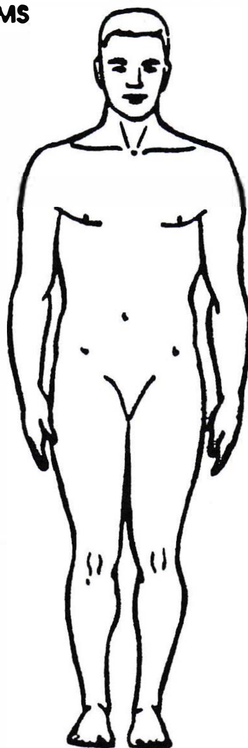
Name of Company and Address ______________________________

____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS





MAJOR COMPLAINT
(Please describe only your major problem)

____

How did this condition develop? (What caused it? How did it start?)

____

____

When was the very first time you were aware of this problem? ____________________

Have you ever had this problem or similar problem before? If yes, please explain:

____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results?

____

____

Has this problem been getting better, worse, or staying the same? ____________________

Is there anything you do that makes your condition worse? ______________________________

____

How has this condition affected your life?

A. Home life ______________________________
B. Occupational life ______________________________
C. Recreational life ______________________________
D. Rest and Sleep life ______________________________

Have you ever been in an automobile accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM ______________________________

____

What surgery has been done? ______________________________

Are you pregnant? ☐ Yes ☐ No

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills ☐ Other (please list) ______________________________

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: ______________________________

Dates consulted: ____________________ For what problem? ____________________

Fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature: ____________________ Social Security No. ____________________ Date ____________________

- -

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

Date of accident: ____________ Hour: ___AM ___PM Location: ____________________

How did accident occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other ____________________

If not an auto collision, please describe the circumstances: ____________________

____

____

Did you report the injury to your foreman or employer? ☐ YES ☐ NO

Did he (they) recommend care at our office? ☐ YES ☐ NO

If auto accident, were you ☐ Driver? ☐ Passenger? ☐ Pedestrian?

If auto collision, were you struck from ☐ Behind? ☐ Right Side? ☐ Left Side? ☐ Front? ☐ Auto was parked

Did your car strike the other(s) involved? ☐ YES ☐ NO; Or did the other car strike yours? ☐ YES ☐ NO ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ YES ☐ NO; To the driver of the other car? ☐ YES ☐ NO

To the driver of your car? ☐ YES ☐ NO; List the extent of the injuries as you know them: ____________________

____

______________________________ Did you require post-accident hospitalization? ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head seems too heavy	☐ Depression	☐ Fainting Spells	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Light bothers Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ ____________

Symptoms other than above: ______________________________

Have you lost any days of work? ☐ YES ☐ NO Dates: ____________________

Name of Your Insurance Company Involved: ____________________

Name of Insurance Company of person responsible for injuries: ____________________

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? ☐ YES ☐ NO

Do you have an attorney who has advised you in this case? ☐ YES ☐ NO Name: ____________________

Address of attorney: ____________________ Phone No: ____________________