WELCOME

one

ABOUT YOU

Today's Date: ____/____/____ File #: ________

Patient Name: ____________________
LAST FIRST MI

What You Prefer To Be Called: ________ ❑ Male ❑ Female

Birthdate: ___/___/___ Age:______ SS#: ________

Mailing Address: ____________________

CITY STATE ZIP

Home Phone #: ____________________

Work Phone #: ________________ Ext: ________

Other Phone #s: ____________________

E-Mail Address: ____________________

Referred By: ____________________

Employer: ________________ How Long? ______

Employer's Address: ____________________

CITY STATE ZIP

Occupation: ____________________

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____________________

Do you have children? ❑ Yes ❑ No How many?________

two

INSURANCE INFO

Co. Name: ____________________

Address: ____________________

CITY STATE ZIP

Phone #: ____________________

Insured's ID#: ____________________

Group # (Plan, Local, or Policy #): ____________________

Insured's Name: ____________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: ____________________

Please inform front desk of 2nd. Insurance source.

three

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): ____________________

Please describe the pain & its location: ____________________

When did condition begin? ___/___/___

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: ____________________

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: ____________________

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where?____________________

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom?________________ Phone#:________________

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact? ____________________

Relation: ____________________

Home Phone #: ______________ Work Phone #: ______________

Who is your Medical Doctor? ______________ Phone #: ______________

HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ______________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

Please list anything that you may be allergic to: ______________

____

List previous surgeries/treatments with dates: ______________

____

List any **past** serious accidents with dates: ______________

____

Family Health History: ______________

____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: ____/____/____

Do you smoke? ❑ No ❑ Yes / How Much? ______ How Long? ______

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? ____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? ____ Nursing? ❑ Yes ❑ No

five

six

ACCOUNT INFO

Person ultimately responsible for account

Name: ______________

Relation: ______________

Billing Address: ______________

____
CITY STATE ZIP

SSN: ______________

D.L.#: ______________

Work Phone#: ______________

Payment method: ❑ CASH ❑ Check

______________ /

❑ Credit Card - Enter card # above (if accepted)

______ Initials — I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

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PAIN CHART

ABOUT YOU

Name: ______________________________ File #: ______________

What is your current weight: ____ lbs., and height, ____ Ft. ____ In..
Please describe your condition:

____

____

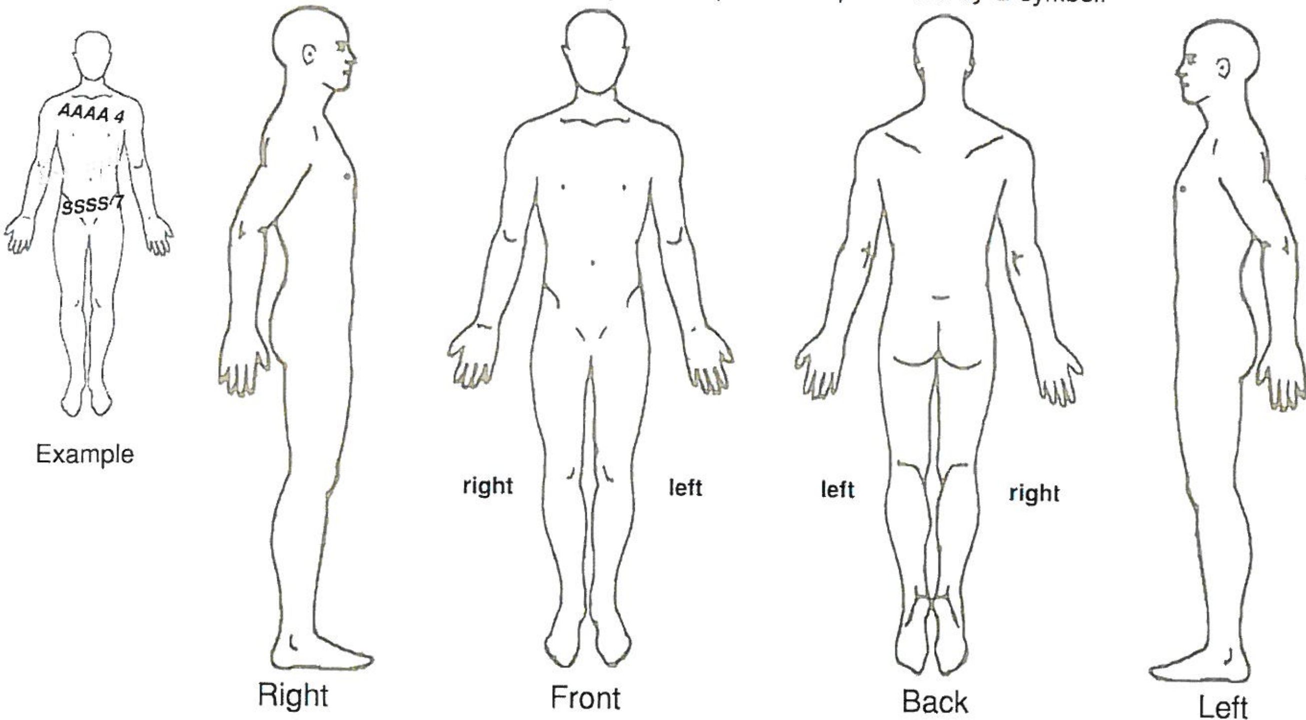
Signature: ______________________________ Date: ___/___/___

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description ➤	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol ⟶	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

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SMART Spine Institute & Surgery Center

Richard Sayegh, D.C.,QME, CMUA • Eduardo E. Anguizola, M.D.,QME • Harry Wurmsdobler, D.C.,QME

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT AND PAYMENT OR HEALTHCARE OPRERATIONS

Name____

Birthdate_____________________________ Social Security_____________________

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the many healthcare professional who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

If you have any questions regarding this form please inform the privacy manager and for your convenience, we have also provided additional information in our reception area.

_________________________________ _____________ _______________

Signature of Patient or Legal Representative Date Witness

3131 Santa Anita Ave., Suite 106
El Monte, CA 91731
office: (626) 444-1676
fax: (626) 445-5155

www.SportsChiro.com

131 East Huntington Drive
Arcadia, CA 91006
office: (626) 445-0326
fax: (626) 445-5155

SMART Spine Institute & Surgery Center
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POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: THAT THE UNDERSIGNED HAS MADE APPOINTED AND CONSTITUTED, AND BY THESE PRESENT DOES HEREBY MAKE AND CONSTITUTE ______________________________D.C./ S.M.A.R.T. SPINE INSTITUTE & SURGERY CENTER, AND HIS DULY AUTHORIZED AGENTS TO BE THE UNDERSIGNED'S TRUE AND LAWFUL ATTORNEY FOR AND IN THE UNDERSIGNED'S NAME, PLACE AND STEAD TO ENDORSE ANY AND ALL CHECKS. DRAFTS, OR MONEY ORDERS WHICH ARE MADE PAYABLE TO THE UNDERSIGNED ALONE OR TO THE UNDERSIGNED AND ______________________________D.C./ S.M.A.R.T. SPINE INSTITUTE & SURGERY CENTER WHICH CHECKS, DRAFTS, MONEY ORDERS ARE TO PAY FOR MEDICAL SERVICES PERFORMED BY ______________________________D.C./ S.M.A.R.T. SPINE INSTITUTE & SURGERY CENTER OR ANY EMPLOYEE OF SAID CLINIC AT THE REQUEST OF OR WITH THE KNOWLEDGE AND APPROVAL OF THE UNDERSIGNED AND/OR MAKER OF THE CHECK, DRAFT OR MONEY ORDER.

THE UNDERSIGNED BY THESE PRESENT DOES THUS GIVE AND GRANT UNTO ______________________________D.C./ S.M.A.R.T. SPINE INSTITUTE & SURGERY CENTER ,AS ATTORNEY THE FULL POWER AND AUTHORITY TO DO AND PERFORM ALL AND EVERY ACT AND THING WHATSOEVER REQUISITE AND NECESSARY TO BE DONE IN AND BOUT THE PREMISES AS FULLY TO ALL INTENTS AND PURPOSES AS THE UNDERSIGNED MIGHT OR COULD DO TO PERSONALLY PRESENT INSOFAR AS THE ENDORSING AND CASHING OF SAID CHECKS ARE CONCERNED.

THE UNDERSIGNED DOES HEREBY RATIFY AND CONFIRM ANY AND ALL ACTIONS TAKEN BY THE SAID ATTORNEY IN ACCORDANCE WITH THIS SPECIAL POWER OF ATTORNEY AND WHICH THE SAID ATTORNEY SHALL DO OF CAUSE TO BE DONE BY VIRTUE OF THESE PRESENT.

IN WITNESS WHEREOF THE UNDERSIGNED HAVE HEREUNTO SET THEIR HANDS, THIS ___________DAY OF ___________ 20____.

PATIENT'S NAME____

PATIENT'S SIGNATURE____

WITNESSED BY ____

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INFORMED CONSENT

PATIENTS REQUEST FOR CHIROPRACTIC AND/OR PHYSIOTHERAPY CARE

Dear Patient, we would like to personally welcome you to our clinic. This notice is to advise you that every type of health care delivery system, including chiropractic care, has some associated risks and the potential for occasional problems of some kind. These problems can include temporary soreness, sprain-strain, bruising, burns, fractures, dislocations, disc injuries, stroke, etc. In considering these issues, remember that human's and their injuries are unique, and treatment that might be very effective for one person might not be as effective for another person. While we are committed to providing you with the best and safest treatment possible, we also have a legal responsibility to advise you about some very rare but potential problems that can occur with chiropractic care and/or physiotherapy. **Before you start your treatment, you need to review this information which is called your "informed consent." No treatment can begin until you have reviewed, this document authorizing treatment based on your informed consent.** Please feel free to discuss any questions or concerns that you may have directly with the Doctor before any treatment at our office.

Remember, we always have time to talk with you about any concerns or questions.

______ **Disc Herniations:** Non-surgical disc injury problems are frequently and successfully treated by skilled chiropractors. Occasionally, chiropractic treatment may aggravate a preexisting disc problem. Very rarely, chiropractic care may cause a disc problem to flare-up or even worsen, especially if the disc is already severely damaged before treatment began.

______ **Soft Tissue Injury:** This term refers to injured muscles; tendons; ligaments; cartilage (and their attachments to bone); blood vessels; and nerves. At times, these tissues (or scar tissue) may be stretched, resulting in temporary pain.

______ **Rib Fractures:** Rarely, chiropractic adjustments may crack a rib bone. This risk is increased in the elderly osteoporotic patient. We adjust all of our patients carefully, and especially our older patients to minimize this risk.

______ **Burns:** Some of our physiotherapy equipment and/or modalities (hot packs, ice, ultrasound, etc.) work by generating heat or cold. Therefore, it is possible for a patient to be burned (by heat or ice) if they do not follow instructions or misuse the equipment. Usually, these are minor problems but they can cause temporary redness, some swelling and mild pain for a few days.

______ **Soreness:** Chiropractic adjustments, traction, massage, stretching exercise, etc., all have the possibility of making a patient sore, on a temporary basis.

______ **Stroke:** Stroke from chiropractic care is VERY uncommon. If you have a history of atherosclerosis, please advise doctor.

______ **Other Problems:** There may be problems or complications that might arise from chiropractic treatment or physiotherapy, other than those described herein. These "other problems or complications" occur so infrequently that it is not possible to anticipate them, predict them or explain them all in advance of starting treatment.

If any problem starts to develop, please advise the doctor.

Disclaimer: Chiropractic is a health care delivery system, and as with any health care delivery system, we **do not** and **can not** promise or guarantee to cure any specific symptom, disease or condition.

______________________	______________________	__________
Doctors Signature	**Patient's Signature**	**Today's Date**

S.M.A.R.T. Spine Institute

OUT OF NETWORK POLICY

Thank you for choosing us for your healthcare needs.

The S.M.A.R.T. Spine Institute may choose to bill your insurance as an out of network provider. What this means to you is that on occasion, your insurance company may issue payment to you (or the insured party), for services rendered here at our facility. If this occurs we ask that you bring us the original check, along with the Explanation of Benefits that is enclosed with that check.

You may also endorse the back payable to S.M.A.R.T. Spine Institute and mail it in to us. You may also deposit the check into your personal account and then send us a personal check for the same amount. If you choose either of these options, please remember to include a copy the Explanation of Benefits that corresponds to the check amount.

If you have any questions, please feel free to contact:

Isabel or Amairini in the billing Department at (626) 445-0326

Thank you for our understanding in this matter.

I understand and agree to this policy: ______________________________

Witness: ______________________________

S.M.A.R.T. Spine Institute Employee

Dated: ______________________

DOCTOR'S NOTES