DIAZ CHIROPRACTIC
Dr. James Diaz

New Patient Information

Name ______ ☐ Female ☐ Male Date ______

What you prefer to be called ______ Age ______ Date of birth ______

Preferred Language ☐ English ☐ Other ______ Race: ☐ White ☐ African American ☐ Other ______

Address ______ City ______ State ______ Zip ______

Home Phone ______ Cell Phone ______

Email Address ______ SS# ______

Preferred Method of Contact ______

Employer ______ Occupation ______ Work Phone ______

Emergency Contact ______ Relation ______ Phone ______

How did you hear about our office? ______

When did your condition begin? ______

Other Doctors seen for this condition? ______

Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of prior condition ______

Mark Areas of Pain on Figures Below

List chief symptoms in order of severity:

(1) ______

(2) ______

(3) ______

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician ______

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications ______

______

______

______

Allergies (Medicine, Food, Environment) ______

______

Previous Surgeries ______

Do you have a PERSONAL history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other serious illnesses ______

Check all symptoms that apply to you:

☐ Headache	☐ Tingling/numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Other ______		☐ Night Pain	☐ Pain unrelieved by rest

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Health Insurance

Policyholder Name ____ Date of Birth ______________________________

Workers Compensation

Is your condition due to an Employment Related Injury? ☐ Yes ☐ No Have you reported it? ☐ Yes ☐ No

Days lost from work ________________________________ Date of accident __________________________________

Employer ____ Work Phone _____________________________________

Supervisor ____ Supervisor# _____________________________________

Auto Accident

Is your condition due to Automobile Accident? ☐ Yes ☐ No Date of accident ______________________________

Auto Accident Insurance Name ______________________ Claim # ____

Adjuster Name ____________________________________ Phone # ____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. John Diaz, and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; and I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Diaz Chiropractic for any reason, I will be responsible for payment of my entire outstanding balance. We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature ____ Date _______________________

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being ________________________________ , age ______ , do hereby authorize, request & direct Diaz Chiropractic, its doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained. As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature ____________________________________ Date Signed ________________

Witness ____