CONFIDENTIAL PATIENT REGISTRATION AND HISTORY

1 Patient Information

Date: ______________

Name: ____
Last Name First Name Initial

Address: ____

____

Home Phone #: ________________________________

Work Phone #: ________________________________

Cell Phone #: ________________________________

E-mail Address: ________________________________

Sex: ☐ M ☐ F Age: _______ Birth date:____________

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security #: ________________________________

Occupation: ________________________________

Employer: ________________________________

Employer Address: ________________________________

Employer Phone #: ________________________________

Hours / Week Worked: ______________________________

IN CASE OF AN EMERGENCY, CONTACT

Name:____________________ Relation: ______________

Phone #:____

Is condition due to an accident? ☐ Yes ☐ No

☐ Auto (Complete Section 3 Below)

☐ Work / Home / Other *(Complete Section 4 on the next page)*

PRIMARY PHYSICIAN: ______________________________

How did you hear about us? ________________________

2 Insurance Information

Health Insurance *(Primary)*

Ins Co.: ________________ Phone:________________

Policyholder name:________________________________

Policyholder birth date:____________________________

Relationship to policyholder:________________________

Policy #: ____________________ Group#:____________

Health Insurance *(Secondary)*

Ins Co.: ________________ Phone:________________

Policyholder name:________________________________

Relationship to policyholder:________________________

Policy #: ____________________ Group#:____________

Complete the following if injury is related to an auto accident.

Motor Vehicle Insurance *(Your PIP Info)*

Owner of vehicle in which you were injured:

____

Ins Co.: ________________ Phone:________________

Policy #: ________________________________

Claim #: ________________________________

Have you retained an attorney? ☐ Yes ☐ No

Name: ________________ Phone:________________

Third Party Information *(Other vehicle that struck yours)*

Name: ________________ Phone:________________

Ins Co.: ________________ Phone:________________

Policy #: ________________ Claim #:________________

3 Auto Accident Information *(If Applicable)*

Date of Injury:____________________ Time:____________ AM/PM State: ☐ TX Other ____________

Describe in DETAIL how your injury occurred: ____

____

____

Were you the: ☐ Driver ☐ Passenger Were you sitting in the: ☐ Front Seat ☐ Back Seat

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side Were you wearing a seatbelt? ☐ Yes ☐ No

Did you know you were going to be hit? ☐ Yes ☐ No Did you brace for impact? ☐ Yes ☐ No

Approximate speed your vehicle was traveling _________mph *OR* were you stopped? ☐ Yes ☐ No

Approximate speed the other vehicle(s) were traveling _________mph

Make & Model of your vehicle:________________________ Make & Model of other vehicle:________________________

Were police notified? ☐ Yes ☐ No Did the police file a report? ☐ Yes * ☐ No

**** If yes, you must provide a copy of this report to this office within 5 business days of today's date.***

What was the approximate damage to vehicle: ☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled

Amount of Damage: $__________________ Was your vehicle towed from the scene? ☐ Yes ☐ No

4 INJURY INFORMATION *(IF APPLICABLE)*

Date of Injury:____________________ Time:__________ AM/PM

Did you go to the hospital after the accident? ______________________________

Have you had X-rays, MRI or CT Scan since this accident? Yes / No If yes, which ones? ______________

____

____

____

Please list any prescribed medications since the accident: ______________________________

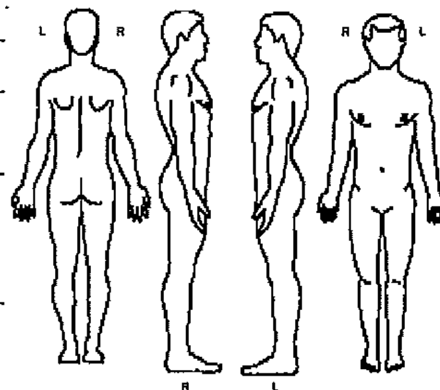
____

____

5 CURRENT COMPLAINTS

What are your present complaints? *(Location of pain, etc.)*______________________________

____



Use an "X" on the drawing to mark where you are experiencing pain *(or other symptoms)*.

When did these symptoms first appear? ______________________________

Do your symptoms interfere with: ☐ Sleep ☐ Daily routine ☐ Work ☐ Recreation

Are you working less hours / days as a result of your injuries? ☐ Yes ☐ No

If yes, please explain ______________________________

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐Walking ☐ Bending ☐ Lying Down

How would you rate your symptoms: ☐ Mild ☐ Moderate ☐ Severe

How would you rate your current symptoms (pain): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Symptoms ... Worst Possible

Since the accident *(if applicable)*, are your symptoms: ☐ Improving ☐ Unchanged ☐ Worsening

6 HOSPITALIZATION / EXAMINATION HISTORY

Have you been to the hospital for *this* condition? ☐ Yes ☐ No If yes, name of hospital? ______________

When did you go? ______________ How did you get there? ☐ Ambulance ☐ Self ☐ Others

Were x-rays taken? ☐ Yes ☐ No If yes, what area(s)? ______________

Were you prescribed any medication? ☐ Yes ☐ No If yes, what medications? ______________

Have you seen any other doctor or received any other treatment for your current condition? ☐ Yes ☐ No

If yes, explain ______________________________

Doctor's name and address: ______________________________

Phone #: ______________ Date(s) seen: ______________ Diagnosis: ______________

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (place "X" in boxes that apply)

Test	Region / Body Part(s)	Date(s)	Test	Region / Body Part(s)	Date(s)
☐ Examination	________	________	☐ EMG / NCV	________	________
☐ MRI / CT	________	________	☐ ________	________	________

7 HEALTH HISTORY / INJURIES / TREATMENTS

INJURIES YOU MAY HAVE HAD IN THE PAST	Description	Date (s)
Auto Accident (s)		
Work Injuries		
Broken Bones		
Other		

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: *(place "X" in boxes that apply)*

- ☐ Muscle disorder
- ☐ Nervous System Disorder
- ☐ Bone Disorder
- ☐ Rheumatoid Arthritis
- ☐ Allergies
- ☐ HIV
- ☐ Gallbladder
- ☐ Diabetes
- ☐ Depression
- ☐ Coughing Blood
- ☐ Stomach, Intestines (GI)
- ☐ Lungs, Asthma
- ☐ Broken Bones
- ☐ Eating Disorder
- ☐ Pace Maker
- ☐ Seizures/Convulsions`
- ☐ A Congenital Disease
- ☐ Excessive Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney, Bladder (GU)
- ☐ Circulatory Problems
- ☐ Osteoarthritis
- ☐ Epilepsy
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Strokes
- ☐ Cancer
- ☐ Ulcer
- ☐ Hernias
- ☐ Ears, eyes, nose, throat
- ☐ Tumors
- ☐ Heart Disease

SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION: Date (s)

Spine Surgeries ☐ Discectomy ☐ Laminectomy ☐ Fusion ☐ Other:__________ __________

Other Surgeries ____________________ __________

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION: *(place "X" in boxes that apply)*

- ☐ Medication *(OTC / Prescription)*
- ☐ Injections
- ☐ Physical Therapy *(Dates:__________)*
- ☐ Massage
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Other: ____________________
- ☐ List ALL Meds: ____________________

Female patients: Start date of most recent menstrual cycle: __________ Are you currently pregnant? ☐ Yes ☐ No

8 YOUR DOCTORS

Please List ALL Doctors involved in your healthcare, present and past. (Use back if necessary)

	Name	Phone
Primary / Family Doctor:		
Orthopedic Doctor:		
Pain Management:		
Neurologist:		
Chiropractor:		

9 YOUR PATIENT INFORMATION

MEDICATIONS List medications you are currently taking.	**ALLERGIES** To medications or substances
Pharmacy Name Phone	

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WELLNESS DALLAS
PT • REHAB • CHIRO

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13520 T.I. Blvd.
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Dallas, TX 75243

Informed Consent for Chiropractic Treatments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other offices or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risk to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand the above information and hereby authorize *James N Kontaratos/Wellness Dallas/Advanced Chiropractic North* to prescribe and provide treatment.

______________________________ (Please Print)

______________________________ (Witness)

______________________________ (Signature)

______________________________ (Date)

______________________________ (Relationship to Patient)

CONSENT TO TREAT A MINOR CHILD

The information I have given this office pertaining to ________________________ is truthful and complete to the best of my knowledge.

______ I authorize the doctors and staff of Advanced Comprehensive Medical/Advanced Chiropractic North to administer such procedures and treatment as they deem necessary to my son/daughter/ward in legal custody. The doctors have implied no guarantee of cure.

______ I authorize the doctors and staff of Advanced Comprehensive Medical/Advanced Chiropractic Northl to treat the above minor without a parent or guardian present.

______________________________ (Print Parent or Guardian Name)

______________________________ (Witness)

______________________________ (Parent or Guardian Signature)

______________________________ (Date)

______________________________ (Relationship to Minor Child)

Office: 972-424-4243
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Plano:
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Dallas, TX 75243

Office Financial Policies

Insurance/Cash/ Attorney
During the course of treatment by, *James N Kontaratos/Wellness Dallas/Advanced Chiropractic North,* charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, patient co-pays, deductibles and co-insurance will be your responsibility and are due at the time of service. If your insurance carrier requires a "referral" from your primary care physician, you will need to contact your PCP for the referral. Treatment provided by this office without the required referral will serve as your consent for treatments not covered by insurance, and will be payable at the time of service. I understand that any claim not paid by my insurance within 60 days from the date filed, will become my responsibility and payable upon billing.

Please check the one that applies:

( ) I certify that I have **no insurance** and will be solely responsible for payment in full.

( ) I certify that the **insurance** reported to *James N Kontaratos/Wellness Dallas/Advanced Chiropractic North* is a complete listing. I understand the office will not extend credit on, or submit a claim for any insurance not reported at the time of service.

( ) I certify that charges will be protected by an **LOP provided by my attorney**. I also understand that, if for any reason, I no longer have attorney representation that I become fully responsible for all charges incurred.

Divorce and Separated Parents
The adult accompanying the child (patient) shall be held responsible for that child's medical expenses, with payment expected at completion of the medical services. It is <u>NOT</u> our office's responsibility to collect payment from the absent parent, even though that parent has been assigned responsibility of the child.

Authorization to release medical information
I authorize *James N Kontaratos/Wellness Dallas/Advanced Chiropractic North*; to release any medical information requested by physicians or insurance companies regarding treatment at this facility. We are required to provide you with a copy of your Notice of Privacy Practice, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgement, if you wish.

Insurance Assignment
I hereby authorize payment to be made directly to *James N Kontaratos/Wellness Dallas/Advanced Chiropractic North*, by my insurance company for any charges for services covered by the terms of my policy. I agree to cooperate, aid and assist the facility in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

Office Supplies
Supplies are considered cash transactions and payable at the time of service. We do not bill insurance companies.

I have read and understand the above information and hereby authorize *James N Kontaratos/Wellness Dallas/Advanced Chiropractic North* to prescribe and provide treatment.

______________________________ (Please Print)

______________________________ (Witness)

______________________________ (Signature)

______________________________ (Date)

______________________________ (Relationship to Patient)

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Assignment of Benefits To

James N Kontaratos, DC &/or Mike K Shah, MD, MPH, MS;

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and in consideration of treatment or services rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning any condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of services rendered to me or my dependents.
IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exist in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by and insurance company, in accordance with the Article 21.55 of the Texas Insurance Code or other applicable insurance of state statues. I, as the patient and/responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.
DEMAND FOR PAYMENT: To any insurance company providing benefits to any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from the judgment upon violation.
THIRD PARTY LIABILITY: If patient(s) treatment for injuries are the result of negligence of any third party, the patient(s) grant lien against any recovery from such third party(s) to the extent of the bills for treatment of services, in favor of the physician/facility named above.
STATUE OF LIMITATIONS: Patient(s) waive the right to claim and Statue of Limitations regarding claims for services or to be rendered by the physician, facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.
LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon checks, drafts or other negotiable instruments representing payment from the insurance company representing payment for treatment or services rendered by the physician/facility named above. I agree that the insurance payment representing an amount in excess of the charges rendered will be credited to my account or forwarded to my address upon request in writing to the physician/facility named above.
TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my treating doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time.

A PHOTOCOPY OF THIS INSTRUMENT MAY SERVE AS ORIGINAL

Printed Name:______________________________

Signature: ______________________________ Date: ____________

Witness: ______________________________ Date:____________