PATIENT PERSONAL/CONFIDENTIAL DATA

No. _____ Email: Date _____

Patient: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Home Phone: _____ cell Phone: _____

Employer: _____ Address: _____

Name of Spouse _____ SS No.: _____ No. of Children: _____

Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____

Nearest relative not living with you? _____ Phone: _____

Who is responsible for payment? ❑ Self ❑ Spouse ❑ Other _____

PATIENT'S INSURANCE

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

SPOUSE'S INSURANCE

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone No.: _____

Purpose of this appointment and list your complaints: _____

_____

Date of illness: _____ Time: _____ ❑ AM ❑ PM Location: _____

How did accident occur? ❑ Auto ❑ On the job ❑ Other, _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

_____

_____

_____

Other Doctor seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? ❑ Yes ❑ No

If yes, please describe: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her 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 to 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.

Patient's Signature: _____

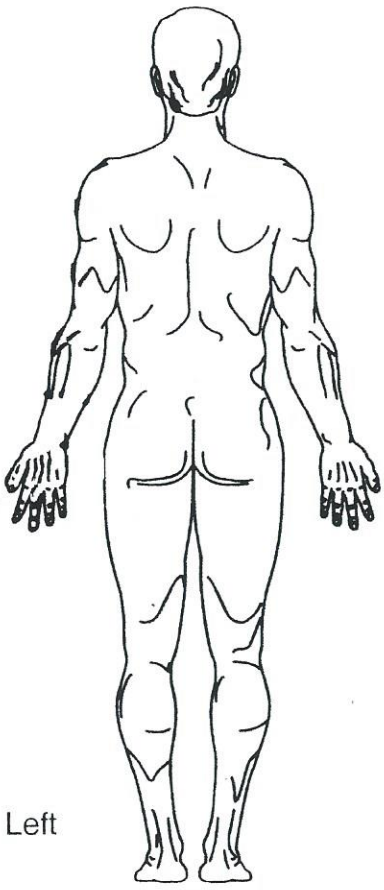
Parent's or Guardian's Signature: _____

Name _____ Date _____ File No. _____

Where is your pain now?

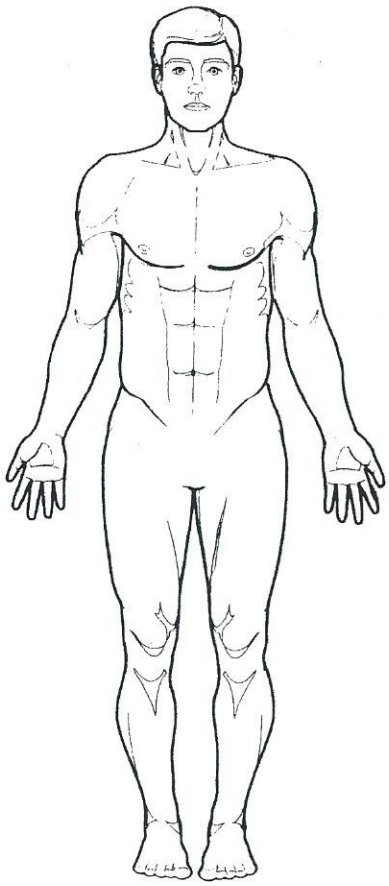
Please use the following symbols to depict the areas on your body where you feel the sensations or pain. Mark the areas of radiation with an arrow ⟶ .

Aching	Numbness	Burning	Tingling Pins and Needles	Stabbing	Dull	Cramping
▲▲▲	= = =	XXX	ooo	///	NNN	SSS



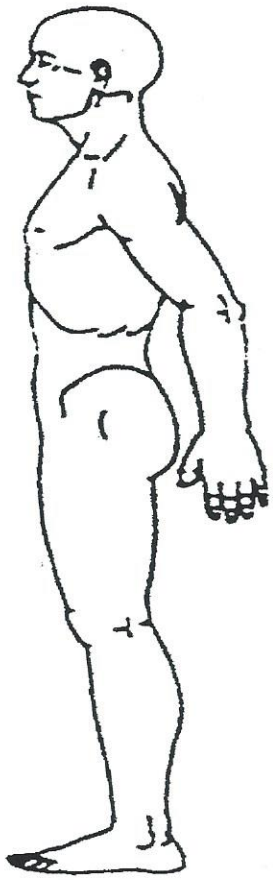
Left

Back



Right

Front



Left

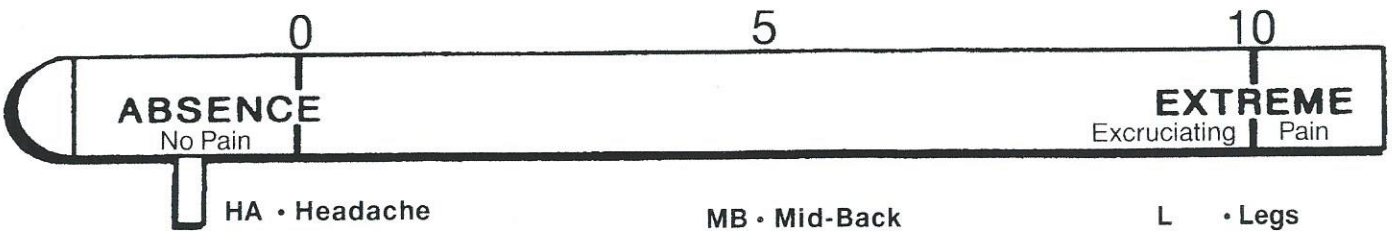
Side (Right or Left)

When did you first notice this condition and describe injury. _____

_____

_____

How bad is your pain now?
Please mark on the line how bad your pain is and indicate:



HA • Headache
N • Neck
AS • Arm(s) /Shoulder(s)
WH • Wrist/Hand/Carpal Tunnel

MB • Mid-Back
R • Ribs
LB • Low-Back

L • Legs
F • Foot
TMJ • Joint

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ **No.:** _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

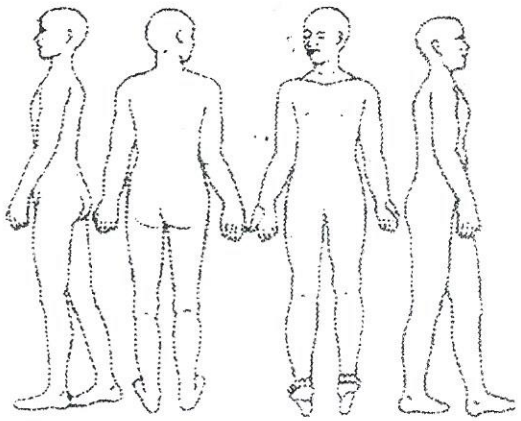
CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

DO NOT WRITE BELOW THIS LINE

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____

ASSIGNMENT OF PROCEEDS , LIEN, AGREEMENT AND AUTHORIZATION

I hereby authorize and direct all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities (payers"), which may elect or become obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, for which medical treatment or medical services were rendered hereunder ("condition") to pay directly and exclusively in the name of _____ such sums as may be owing to **Dr. Pederson** charges incurred by me at **Dr. Kevin Pederson D.C. Chiropractic Clinic** relating to my condition ("charges"), with such payments to be made exclusively in the name of **Dr. Kevin Pederson DC**. I further grant a lien to **Dr. Pederson** in accordance with the definitions, rights and remedies of Texas law including specifically, but not limited to, Texas Business & Commerce Code 9.102 and the comments thereunder, with respect to my outstanding medical balance. This lien shall apply to all payers and to the full extent of Texas law. For the purposes of this medical assignment and medical lien, "benefits" shall include but not be limited to proceeds from any settlement, judgment, or verdict, as well as any proceeding or recovery obtained as a result of commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no fault coverage, uninsured an underinsured motorist coverage, third-party liability distribution or disability distribution.

I authorize **Dr. Pederson** to release any information regarding my treatment or pertinent to my case (s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to releases to **Dr. Pederson** any and all information regarding any coverage or benefits which I may provide for reimbursement to **Dr. Pederson** for medical services provided to me including, but not limited to, the amount and type of insurance coverage, the amount paid out on the condition thus far, and the amount of any outstanding claims. I hereby direct **Dr. Pederson** to file a copy of the assignment and lien with all payers. I hereby authorize **Dr. Pederson** to file a copy of this assignment and lien with all public records in accordance with Texas law so as to provide public notice of this assignment and lien. In the event I retain one or more attorneys to represent me for the recovery for injuries which sustained which were the basis of the condition on which I sought medical treatment, I direct each and every attorney to issue a letter of protection to **Dr. Pederson** to protect _____'s outstanding medical charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of **Dr. Pederson** .

I understand that I will become personally responsible should any payer fail to honor this assignment. I understand that my personal responsibility is in addition to the obligation of any other payer, to the extent of my outstanding medical balance, costs, and expenses and enumerated herein, including attorney's fees. I further understand and acknowledge that **Dr. Pederson** has rendered good an valuable services and consideration for this assignment and lien including forbearance of payment for services rendered for a reasonable period. In the event that **Dr. Pederson** must take any raction to collect an outstanding balance on my account, I acknowledge and agree to be liable to reimburse **Dr. Pederson** for all cost incurred, including collection cost, court cost, expert witness fees, travel cost, and reasonable attorney's fees.

This Assignment and Lien constitutes the complete agreement between the parties and revokes any other written agreements or oral agreements between the parties. I acknowledge that I have read this Assignment, Lien, and Agreement and that I execute this document freely, knowingly, and that I have had the opportunity to have this document reviewed by an attorney of my choice, and to rely upon their advice prior to signing this Assignment, Lien, Agreement and Authorization. I understand that this is a binding legal document and that this Assignment, Lien, Agreement and Authorization affects legal rights that I may have to settlement, judgement, or verdict proceeds as a result of the injuries that I have suffered.

Patient Name: (Please Print) _____

Patient Signature _____ DATE _____

Name of Custodial Parent or Legal Guardian (Please Print) _____

PATIENT NAME : _____

ACKNOWLEDGEMENT OF ACCURACY

With my signature, I affirm that all information, including insurance and subscriber information I have provided to the staff of Pederson Chiropractic is accurate and as thorough as possible.

_____ _____

Signature of Patient / Legal Guardian **Date**

RECEIPT OF FINANCIAL POLICY

I have received, read, and understand the Patient's Bill of Rights as well as the Financial Policy of Pederson Chiropractic.

_____ _____

Signature of Patient / Legal Guardian **Date**

RECEIPT OF NOTICE REGARDING PRIVACY INFORMATION

I have read, and understand the notice regarding Privacy of Personal Health Information presented to me in the Pederson Chiropractic waiting room.

_____ _____

Signature of Patient / Legal Guardian **Date**

AUTHORIZATION LIST

I hereby authorize the following person or persons to receive medical information regarding my care.

Name	**Relationship**
1. _____	_____
2. _____	_____
3. _____	_____

_____ _____

Signature of Patient / Legal Guardian **Date**

ASSIGNMENT OF BENEFITS

I authorize the assignment of any payment by my insurance to Pederson Chiropractic.

_____ _____

Signature of Patient / Legal Guardian **Date**

_____ _____

Staff Signature (Pederson Chiropractic) **Date**