Prada Chiropractic @ Denver Sports Recovery

PATIENT INFORMAITON:

Name_____ Nickname_____
Address_____ City_____ State_____ Zip Code_____
Home #_____ Cell #_____ D.O.B._____
Age_____ Gender_____ Marital Status __Single __Married __Widowed __Divorced __Unspecified
Work Status __Employed __Unemployed __Retired Occupation_____ Employer_____
Are you a college student? __Yes __No __Full Time __ Part Time School_____
Email Address_____
Emergency Contact_____ Relationship_____ Phone #_____

HEALTH INSURANCE INFORMATION:

Health Insurance Company_____ Member ID #_____
Group #_____ Insurance Contact phone #_____
Relationship to Subscriber: __Self __Spouse __Child __Other
Name of Subscriber_____ Subscriber D.O.B._____
Do you have Secondary/Supplemental Insurance?_____
Secondary Insurance_____ Insured ID #_____ Group #_____

ACCIDENT INFORMATION:

Is your current condition related to an accident? __Yes __No
Date of Accident_____ Type of Accident __Auto __Work __Other_____
Claim #_____ Adjuster_____ Phone #_____
Attorney's name_____ Contact #_____ Email (if applicable)_____

NOTICE OF PRIVACY PRACTICE SUMMARY:

This summary discloses how health information about you may be used. At your request, Prada Chiropractic and Denver Sports Recovery can provide you with the full notice of your privacy rights. Prada Chiropractic and Denver Sports Recovery uses health information about you for treatment and to obtain payment for treatment with your authorization. Prada Chiropractic and Denver Sports Recovery will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Prada Chiropractic and Denver Sports Recovery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally liable for any charges, whether or not paid by insurance, for chiropractic services rendered to me. I hereby authorize the doctors to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

FINANCIAL RESPONSIBILITY:

I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of service (includes health insurance copays/deductibles/coinsurance).

CONSENT FOR TREATMENT OF MINORS:

I hereby authorize Dr. Prada, Dr. McMahon, Dr. Keys and assistance at Denver Sports Recovery to administer examinations and care as deemed necessary to the patient under the age of 18 years old. Parent/Guardian (Printed)_____

SIGNATURE:

Patient Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

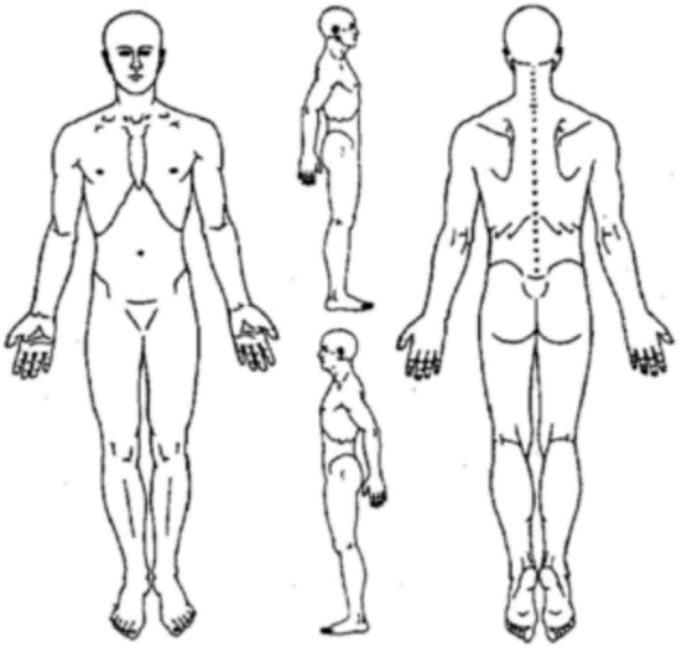
Prada Chiropractic @ Denver Sports Recovery

Patient Name_____

How did you hear about the service you are here for:
_____
If applicable, who referred you_____
Please list physical activities you participate regularly in:
_____
Reason for Visit_____
How long have you been dealing with symptoms?
_____
Have you seen a Chiropractor in the past? __Yes __No

Please Describe your symptoms_____
_____
How did your symptoms start?_____
_____
Date symptoms began_____
What best describes the nature of your symptoms?
__Sharp __Dull ache __Numbness __Tingling
__Burning __Stabbing __Dizziness __Other_____

Average pain Intensity:
Currently:
. no pain 1 2 3 4 5 6 7 8 9 10 worst pain
At its worst:
. no pain 1 2 3 4 5 6 7 8 9 10 worst pain
At its best:
. no pain 1 2 3 4 5 6 7 8 9 10 worst pain



Does your pain interfere with your daily activities?
__Not at all __A little bit __Moderately
__Quite a bit __Extremely
How often are your symptoms present?
__0-25% __26-50% __51-75% __76-100% (Constant)
Is this: __Work Related __Auto Related
. __Sports Related __Other

List anything that aggravates your condition:
_____
_____
List anything that relieves your condition:
_____
_____
Have you been treated for any health condition by a physician in the last year? __Yes __No
If yes, briefly explain_____
_____

Date of last physical examination:_____

Women Only: Are you pregnant? ___Yes ___No

Have you had x-rays, MRI, CT scan taken for this condition?
__Yes __No
If yes, exam/date_____

Have you ever suffered from: (check any that apply):

___ Dizziness	___ Arthritis	___ Digestive Disorders
___ Backaches	___Headaches	___Neuropathy
___ Nervousness	___Heart Trouble	___Numbness
___Sinus Trouble	___ Diabetes	___Asthma
___Anemia	___ Hernia	___Neuritis
___ Cancer	___Blood Clot	___High Blood Pressure

Personal Incident History:
Broken Bones_____
Hospitalized_____
Auto Accident_____
Major Sprains/Strains_____
Surgeries_____
Head Injuries_____
Stroke_____

Family Medical History:
__Cancer __High Blood Pressure __Diabetes
__Heart Problems/Stroke __Other_____

Medications_____
_____
Allergies_____
Vitamins/Supplements/Herbs_____
_____

I certify to the best of my knowledge the above information is complete and accurate. I agree to notify this doctor immediately whenever I have changes in my health condition.

Patient Signature:_____
Date:_____