PRESTIGE SPINAL CARE

BP:	H:
P:	W:

PATIENT INTAKE

Demographics:

Last Name:	First Name:	DOB:	Age:	Email:
Street Address:	City/State:	Zip Code:		Phone Number:
Status (Circle One): Single Married Partnered Divorced Widowed				Gender: Female Male
Emergency Contact Name:	Relationship:			Phone Number:
Emergency Contact Name:	Relationship:			Phone Number:

1. How did you hear about us? Facebook WGNO Google Insurance Current Patient: _____
2. Are you here because you were involved in a motor vehicle accident? If yes, date of injury: _____
3. Are you here because you were injured at your place of employment? If yes, date of injury: _____
4. Are you here because you were involved in another type of accident? If yes, please explain and include date of injury:_____
5. Will you be using health insurance? If yes please provide us with your insurance card. If you do not have your card with you, please fill out the information below:

Primary Insurance Company: _____ Subscriber ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Patient or Parent/Guardian Signature: _____ Date: _____

Primary Complaint:

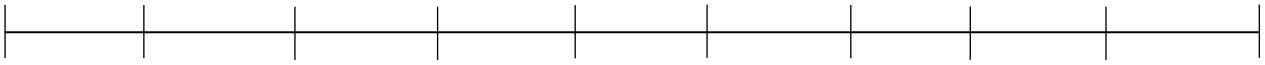
1. What is the main reason for your visit today? _____

   _____

2. Where and when did your primary complaint begin? _____

   _____

3. Using the below pain scale for reference, please answer questions 4-7:



1. No Symptoms	2. Slight Discomfort	3. Does Not Affect Activity	4. Affects Personal Activity	5. Prevents Personal Activity	6. Limits Work Schedule	7. Prevents All Working Activity	8. Prevents All Activity	9. Keeps Me Bedridden	10. Causes thoughts of suicide

4. What is the severity of your primary complaint **right now**: 1 2 3 4 5 6 7 8 9 10

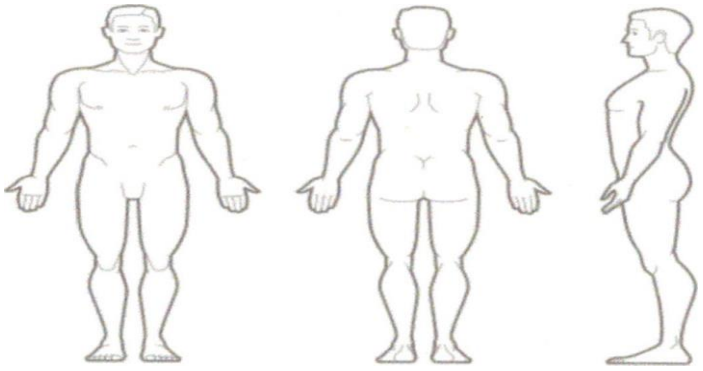
5. What is the severity of your primary complaint **on average**: 1 2 3 4 5 6 7 8 9 10

6. What is the severity of your primary complaint at its **best**: 1 2 3 4 5 6 7 8 9 10

7. What is the severity of your primary complaint at its **worst**: 1 2 3 4 5 6 7 8 9 10

Mark the areas of your chief complaint on the diagrams to the right. Include any descriptors or comments that you feel are important.

If your symptoms travel to other areas of your body, mark the diagrams to reflect how the symptoms seem to move.



Doctor Comments: _____

_____

_____

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HEALTH HISTORY: (Mark all of the following conditions that apply)

CONSTITUTIONAL	MUSCULOSKELETAL	NEUROLOGICAL	CARDIOVASCULAR	RESPIRATORY
Fever Weight Loss Obesity Loss of Appetite Fatigue Anxiety Allergies	Back Pain Headaches Extremity Pain Bone Demineralization Unstable Fracture Spinal Infection Spinal Bone Tumors	Sudden Numbness Sudden Headache Loss of Sensation Confusion Dizziness Slurred Speech Loss of Balance	High Blood Pressure Heart Disease Arterial Aneurysm Angina Irregular Heart Beat Bleeding Disorder Heart Attack	Asthma COPD Common Cold Emphysema Pneumonia Cancer Pneumothorax
EYES	**ENMT**	**GENITOURINARY**	**GASTROINTESTINAL**	**DISEASE HISTORY**
Vision Trouble Double Vision Night Blindness Glaucoma Cataracts Discharge Droopy Eyelids	Hearing Loss Tinnitus Vertigo Nose Bleeds Dry Mouth Change in Taste Bleeding Gums	Kidney Infection Loss Bladder Control Urine Color Change Painful Urination Urine Leakage Urgency Blood in Urine	Gerd IBS Crohns Bleeding Disorder Cramping	Stroke Heart Attack Diabetes Cancer HIV / AIDS

SOCIAL HISTORY:

How often do you exercise? Never 1x/ week 2x / week 3x/ week 4x / week

How often do you use tobacco?	Never	Daily	Weekly	Monthly	Socially
How many alcoholic beverages do you drink each week?		1 -2	3-4	5+	
How many coffee beverages do you drink each week?		1 -2	3 -4	5+	
How many soda or sugar beverages do you drink each week?		1 -2	3 -4	5+	

List all of the prescription medications you are currently taking.

List all of the over-the-counter medications and nutritional supplements you are currently taking.

List all of the surgical procedures that you have had.

List all of the times you have been hospitalized.

List all significant past traumas that you have had.

Mark all the following that are in your **family history:** Heart Disease Stroke/TIA Diabetes Cancer

PRESTIGE SPINAL CARE

CONSENT TO X-RAY

I hereby authorize Prestige Spinal Care and whomever the clinician may designate as his assistant(s) to take x-rays of myself (or said minor).

Printed Name: _____ **Signature:** _____ **Date:** _____

PARENT OR GUARDIAN (IF MINOR)

Printed Name: _____ **Signature:** _____ **Date:** _____

Pregnancy Release*

Date of onset of patient's last menstrual period (LMP): _____

I hereby release Prestige Spinal Care from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date. I have been informed adequately of the potential effects of radiation on a developing fetus. If a pregnancy test has been performed, I am also aware that this test is not 100% accurate and may yield false results.

PATIENT:

Printed Name: _____ **Signature:** _____ **Date:** _____

PARENT OR GUARDIAN (IF MINOR)

Printed Name: _____ **Signature:** _____ **Date:** _____

*Must be completed for all females of childbearing age and signed in the patient, or parent/guardian's own handwriting.

Assignment of Benefits: Assignment of Cause of Action/Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to Dustin Etemadi, DC, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or benefits that the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists 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 loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code 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 of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Prestige Spinal Care, and send to 4810 W. Panther Creek Dr., Ste. 105, The Woodlands, TX 77381.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly Prestige Spinal Care, and send to 4810 W. Panther Creek Dr., Ste. 105, The Woodlands, TX 77381.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case. Signature of Patient and/or Responsible Parties:

Signature: _____ Date: _____

PRESTIGE SPINAL CARE

H.I.P.A.A Open Door Policy & Group Insurance Disclaimer

It is the policy of this office to keep patient information confidential regarding care. We are required to transfer information regarding insurance related care to the carrier regarding patient diagnosis, history; exam findings care plans, prognosis, and patient status. It is our office policy to render our services for patients in an open room which may be visible to anyone in the reception area. This is both for patient/doctor safety. It is possible for others in the reception area to overhear your protected health information during administration of care. If you need to speak with the doctor about a matter which must be kept private, let us know in advance and we will make allowances for the discussion to be held behind a closed door.

The financial policy for Prestige Spinal Care is that all services must be paid at the time services rendered unless prior arrangement has been made. We strive to keep fees affordable. When we have to bill a third party and wait for payment, our fees must be adjusted for the added time & expense incurred for billing.

We only bill Auto P.I.P, Health insurance, and LOP (from attorney) Claims. Pre-Payment for advanced visits are ALWAYS accepted. I have read and understand the above stated policies and agree to abide by them and authorize the administration of my care to this facility.

Signature: _____ Date: _____