

**PATIENT INFORMATION**  
**INFORMACIÓN DEL PACIENTE**

Name/Nombre \_\_\_\_\_

Address/Dirección \_\_\_\_\_

City/Ciudad \_\_\_\_\_ State/Estado \_\_\_\_\_ Zip/Código postal \_\_\_\_\_

Home Phone/Teléfono de casa \_\_\_\_\_ Cell phone/Teléfono móvil \_\_\_\_\_

Email/correo electrónico \_\_\_\_\_

Occupation/Ocupación \_\_\_\_\_ Employer/ Empleador \_\_\_\_\_

Employer address/Dirección del empleado \_\_\_\_\_

City/Ciudad \_\_\_\_\_ State/Estado \_\_\_\_\_ Zip/Código postal \_\_\_\_\_

Age/Edad \_\_\_\_\_ Date of birth/Fecha de nacimiento \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_ Male/ Masculino \_\_\_ Female/ Femenino

Spouse/Espos(a) \_\_\_\_\_

Preferred method of contact: \_\_\_ Home phone \_\_\_ Cell phone \_\_\_ Text \_\_\_ Email

Método de contacto preferido: \_\_\_ Teléfono de la casa \_\_\_ Teléfono celular \_\_\_ Texto \_\_\_ Correo electrónico

How were you injured?/¿Cómo te lastimaste? \_\_\_ Auto accident/Accidente de auto

\_\_\_ Work injury/ Lesión en el trabajo \_\_\_ Other/Otro \_\_\_\_\_

Do you have an attorney?/¿Tienes un abogado? \_\_\_ Yes/Si \_\_\_ No

Do you have car insurance?/¿Tiene seguro de automóvil? \_\_\_ Yes/Si \_\_\_ No

Please give us the following information ONLY IF YOU DON'T HAVE AN ATTORNEY  
Por favor dénos la siguiente información SÓLO SI NO TIENE UN ABOGADO

Name of insurance company/ Nombre de la compañía de seguros \_\_\_\_\_

Date of injury/ Fecha de accidente \_\_\_\_\_

Claim number/ Numero de reclamo \_\_\_\_\_ Adjuster/ajustador \_\_\_\_\_

Person responsible for injury/ Persona responsable de la lesión \_\_\_\_\_

Name of your insurance company/ Nombre de su compañía de seguros \_\_\_\_\_

Policy number/ Número de póliza \_\_\_\_\_

Do you have a copy of a police report?/¿Tienes una copia de un informe policial? \_\_\_ Yes/Si \_\_\_ No

# AUTHORIZATION & ASSIGNMENT OF BENEFITS

*Dr. Kenneth D. Pace, D.C., Dr. Kenneth D. Pace, D.C., LLC,  
The Injury Center of Kenner*

I consent to all diagnostic procedures, chiropractic care, medical care, and other treatments deemed necessary by the providers listed above.

I authorize the release of any and all information from my medical records regarding my condition and my treatment to: my other physicians for purposes of treatment, my insurance company for purposes of submitting insurance claims, my attorney for use in pursuing any claims that I may have in connection with the conditions for which I am being treated, and any third party who has assumed responsibility for my bill for purposes of verification and payment. This release will expire sixty months after termination of my treatment. I may revoke this release in writing at any time.

I authorize the above listed providers to request and receive any and all records deemed necessary from my insurance company(s) or any third party who may hold records which may help properly administer care, or to properly maintain files or records pertaining to my care or treatment in this office, whether those records be medical, chiropractic, or insurance, and I further instruct any insurance company or other party who holds or controls any such records to release said records to you at your request.

I hereby authorize, request and assign direct payment of medical insurance benefits to any and all of the above listed providers for services rendered and, to the extent permitted by law, I name the above listed providers as the mandatary of any health insurance, reimbursement plan, or proceeds of any settlement, adjudication or verdict applicable to or arising out of any charges for services rendered in connection with their treatment of me, to the full extent of such charges. I authorize the provider to sign, endorse, and deposit such checks, notes or other form of payment into the providers account in recognition of money owed by me for services rendered. I understand that should one of the listed providers endorse a check payable to me or payable to the provider, that provider is authorized to apply these funds to pay any balance that I may have with the office and the provider will remit to me in a timely fashion any remaining funds.

In the event that any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company, and authorize you to prosecute said action either in my name or your name as you see fit. I agree to pay for services rendered. I understand that whatever amount the listed providers do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I understand that in the course of treatment I may be referred for x-rays or other diagnostic studies or therapeutic services to The Injury Center of Kenner and/or Dr. Kenneth D. Pace LLC, and that the fees for those services will be added to and billed with charges from this office. I further understand that Dr. Kenneth D. Pace, D.C. also owns an interest in The Injury Center of Kenner.

I understand and agree if my current policy or any third party responsible for payment fails to make a direct payment to the provider, I agree to immediately endorse and deliver such check(s) and forward it to the above provider (with such provider authorized to deposit these checks on my behalf) for the professional or medical expenses incurred, and otherwise payable to me. I UNDERSTAND THIS IS AN IRREVOCABLE AND DIRECT ASSIGNMENT OF BENEFITS.

I certify that all information given by me is true and correct.

A photocopy of this assignment shall be regarded as an original.

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**The Injury Center of Kenner**  
**Acknowledgement of Privacy Practice Procedures**  
**(Aviso de Prácticas de Privacidad)**

Patient Acknowledgment (Reconocimiento de Paciente)

By signing my name below, I acknowledge that the Privacy Practice Procedures have been explained to me, and I understand that I may request a copy at any time. If you have any questions about our Privacy Practices please contact any staff member in this office.

Al firmar mi nombre abajo, reconozco que me han explicado los procedimientos de práctica de privacidad, y yo entiendo que puedo solicitar una copia en cualquier momento. Si usted tiene alguna pregunta sobre nuestras prácticas de privacidad, por favor contacte a un miembro del personal en esta oficina.

Patients name (Nombre de paciente): \_\_\_\_\_

Patients signature (Firma de paciente): \_\_\_\_\_

Date (Fecha): \_\_\_\_\_

If signed by someone other than the patient, please indicate (Si es firmado por alguien que no sea el paciente, indique): \_\_\_\_\_

Relationship (Relacion)  Parent or guardian (Padre o guardián):

Guardian or conservator of an incompetent patient (Tutor o curador de un paciente incompetente)

Other (otro) Please specify (Por favor especifique) \_\_\_\_\_

Exceptions (Excepciones)

The Injury Center of Kenner may share my health information with the following individuals:  
(puede compartir mi información de salud con las siguientes personas)

Name (nombre): \_\_\_\_\_ Initials(iniciales)

The Injury Center of Kenner may send a report to my attorney:  
(puede enviar un informe a mi abogado(a):

Name (nombre): \_\_\_\_\_ Initials (iniciales)

The Injury Center of Kenner may send a report to my primary care physician:  
(puede enviar un informe al médico de atención primaria)

Name (nombre) \_\_\_\_\_ Initials (iniciales)

Office use only (Uso solamente de oficina)

We attempt to obtain written acknowledgement of Privacy Procedures, but it could not be obtained because: (Se intentó obtener acknowledgement por escrito de los procedimientos de privacidad, pero no se pudo obtener debido:

Individual refused to sign (Individual se negó a firmar) Witness (Testigo): \_\_\_\_\_  
Date (Fecha): \_\_\_\_\_ Witness name Print (Testigo nombre) \_\_\_\_\_

History (Historia)

Name (Nombre): \_\_\_\_\_ Date: \_\_\_\_\_

1. Please list your symptoms. If you have more than one please check all that apply. (Por favor indique sus síntomas. Si usted tiene más de uno, por favor marque lo que corresponda.)

- Headaches (dolor de cabeza)
- Neck (cuello)
- Upper back (espalda arriba)

- Mid-back (mita de espalda)
- Lower back (espalda abajo)
- Other (otro):

2. Location of symptom: (Localización de síntomas)

- Right side (lado derecho)
- Left side (lado izquierdo)

- Middle (en medio)
- Both sides (los dos lados)

3. Headache location (Localización del dolor de cabeza)

- Forehead (frente)
- Temple(s) (templos)
- Side(s) of head (lado (s) de cabeza)

- Base of skull (base del cráneo)
- Around/behind eyes (alrededor o atrás de los ojos)

4. Please describe your symptoms. (Por favor indique su síntomas.)

- Ache/sore (Dolor)
- Throbbing (palpitante)
- Burning (ardiente)

- Stiffness (rigidez)
- Shooting (disparo)
- Tingling/numbness (Hormiguero o dormido)

5. When do you feel the symptoms? (cuando siente los síntomas?)

- Non-Stop (todo el tiempo)

- Comes and goes (por ratos)

How often? (cada cuanto?) \_\_\_\_\_

6. How long have you felt your symptoms? (hace cuanto ha tenido los síntomas?) \_\_\_\_\_

Date of injury (fecha de herida) \_\_\_\_\_

7. What caused your symptoms? (que causó los síntomas)

- Don't know (no sabe)
- Car accident (accidente de vehiculo)

- Work injury (accidente de trabajo)
- Sports injury (lesiones deportivas)

8. If your symptoms are from an injury, please describe what happened in detail. (Si los síntomas son de una lesión, por favor describa lo que sucedió en detalle)

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History (Historia) Name (Nombre): \_\_\_\_\_ Date: \_\_\_\_\_

9. Do the symptoms radiate? (sus síntomas dispersan?)

- |   |   |
|---|---|
| <input type="checkbox"/> None (ninguna)           | <input type="checkbox"/> Fingers (dedos)          |
| <input type="checkbox"/> Right (lado derecho)     | <input type="checkbox"/> Buttocks (glúteo)        |
| <input type="checkbox"/> Left (lado izquierdo)    | <input type="checkbox"/> Thighs (muslo)           |
| <input type="checkbox"/> Both (los dos lados)     | <input type="checkbox"/> Lower leg (pierna abajo) |
| <input type="checkbox"/> Upper arm (brazo arriba) | <input type="checkbox"/> Foot (pie)               |
| <input type="checkbox"/> Forearm (antebrazo)      | <input type="checkbox"/> Toes (dedos de los pies) |
| <input type="checkbox"/> Hand (mano)              |   |

10. Please describe radiating symptoms (Por favor describa síntomas irradiados)

- |   |  |
|---|--|
| <input type="checkbox"/> Pain (dolor)       | <input type="checkbox"/> Tingling (hormiguero) |
| <input type="checkbox"/> Numbness (dormido) |  |

11. What makes your symptoms worse? (que hace que sus síntomas empeoren?)

- |   |  |
|---|--|
| <input type="checkbox"/> Sitting (sentado)          | <input type="checkbox"/> Head movement (movimiento de la cabeza) |
| <input type="checkbox"/> Standing (parado)          | <input type="checkbox"/> Arm movement (movimiento del brazo)     |
| <input type="checkbox"/> Driving (manejando)        | <input type="checkbox"/> Lying on side (acostado de lado)        |
| <input type="checkbox"/> Bending (flexión)          | <input type="checkbox"/> Lying on stomach (acostado de estomago) |
| <input type="checkbox"/> Lifting (levantando cosas) | <input type="checkbox"/> Lying on back (acostado de espalda)     |

12. What makes your symptoms better? (que hace sus síntomas mejor?)

- |  |   |
|--|---|
| <input type="checkbox"/> Aspirin/Tylenol (Aspirina/ Tylenol)     | <input type="checkbox"/> Heat (calor)         |
| <input type="checkbox"/> Ibuprofen                               | <input type="checkbox"/> Cold (helado)        |
| <input type="checkbox"/> Pain pills (pastillas para el dolor)    | <input type="checkbox"/> Rest (descanso)      |
| <input type="checkbox"/> Muscle relaxers (relajantes musculares) | <input type="checkbox"/> Exercise (ejercicio) |
| <input type="checkbox"/> Massage (masaje)                        | <input type="checkbox"/> Nothing (nada)       |

13. Please rate your symptoms (Por favor evaluar los síntomas) (10 is worse) (10 es el peor)

1  2  3  4  5  6  7  8  9  10

This space for doctor's use only (este espacio para uso medico)

Signature: (Firma)

Date: (Fecha)