PATIENT INFORMATION

NAME:____

HOME ADDRESS:______________________CITY:_______________STATE:_____ZIP:________

HOME PHONE:______________CELL PHONE:________________OCCUPATION:______________

E-MAIL:________________________________EMPLOYER:____________________________

EMPLOYER ADDRESS:____________________CITY:_____________STATE:_____ZIP:________

WORK PHONE:_______________________DATE OF BIRTH:____/____/______SEX:___M ___F

SPOUSE:______________________SPOUSE'S EMPLOYER:___________________________

EMPLOYER ADDRESS:____________________CITY:_______________STATE:___ZIP:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

Referred by Friend/Relative: Name______________________ My Physician: Dr.____________________

Attorney__________________________

INSURANCE INFORMATION

TYPE OF INJURY: ___CAR ACCIDENT ___WORK INJURY ___SLIP AND FALL ___HOME INJURY

___OTHER:____

DATE OF INJURY:________________TIME:__________WHERE DID IT HAPPEN:________________

HAVE YOU RETAINED AN ATTORNEY? ___YES ___NO NAME:______________________________

IF INJURED ON THE JOB, DID YOU NOTIFY SUPERVISOR? ___YES ___NO DATE:________________

IF INJURED ON THE JOB, WAS AN INJURY REPORT COMPLETED?___YES ___ NO DATE:_____________

DO YOU HAVE HEALTH INSURANCE?___YES___NO NAME OF HEALTH INSURANCE_________________

DO YOU HAVE MED PAY WITH YOUR CAR INSURANCE? ____YES____NO

YOUR CAR INSURANCE COMPANY NAME _____________________POLICY NUMBER________________

DO YOU HAVE UNINSURED MOTORIST COVERAGE?_____YES____NO

LIABILITY INFORMATION (PERSON WHO HIT YOU): CLAIM NUMBER__________________________

ADJUSTER'S NAME___________________________INSURANCE COMPANY______________________

IT IS THE POLICY OF THIS OFFICE THAT WE FILE TO ALL AVAILABLE INSURANCE. BY SIGNING BELOW YOU UNDERSTAND AND AGREE WITH THIS POLICY AND WILL PROVIDE THIS OFFICE WITH ALL INSURANCE INFORMATION THAT IS NEEDED.

____ DATE:__________________

Patient or Representative's Signature

AUTHORIZATION & ASSIGNMENT OF BENEFITS

Dr. Kenneth D. Pace, D.C., Dr. Kenneth D. Pace, D.C., LLC, Medical Rehab 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 Medical Rehab 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 Medical Rehab 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

Medical Rehab Accident Injury Center
Acknowledgement of Privacy Practice Procedures
(Acuse de Privacidad Procedimientos de Práctica)

Patient Acknowledgemte (Reconocimiento de Pacientes)

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 los procedimientos de práctica de privacidad se han explicado a mí, y yo entiendo que puedo solicitar una copia en cualquier momento. Si usted tiene alguna pregunta sobre nuestras prácticas de privacidad por favor póngase en contacto con cualquier miembro del personal en esta oficina

Patients name (nombre de paciente): ____________________
Patients signature (firma de pciente): ____________________
Date (fetcha):____________________________________

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

Relationship (relation) __Parent or gusrdian (Padre o guardián):
__Guardian or conservator of an incompetent patient(Tutor o curador de un paciente incompetent)
__Other (otro) Please specify(Por favor especifica)_____________

Exceptions(Excepciones)

Medical Rehab Accident Injury may share my health informatiom with the following individuals:
(puede compartir mi información de salud con las siguientes personas)

Name (nombre):____________________________________ Initials(iniciales)

Medical Rehab Accident Injury Center may send a report to my attorney:
(puede enviar un informe a mi abogo(a):
Name (nombre):____________________________________ Initials (iniciales)

Medical Rehab Accident Injury Center may send a report to my primary care physician:
(puede enviar un informe al médico de atención primaria)
Name (nombre)____________________________________ Inintials (iniciales)

Office use only (Uso solamente de oficina)

We attempt to obtain written acknwoledgement of Privacy Procedures, but it could not be obtained because: (Se intentó obtener acknwoledgement 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 (Fetcha):_________ 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 sintomas)**

   - □ 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 craño)
   - □ Around/behind eyes (alrededor o atras de los ojos)

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

   - □ 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 sintomas?)**

   - □ 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 trabjo)
   - □ 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 sintomas dispersan?)

□ None (ninguna)
□ Right (lado derecho)
□ Left (lado izquierdo)
□ Both (los dos lados)
□ Upper arm (brazo arriba)
□ Forearm (antebrazo)
□ Hand (mano)
□ Fingers (dedos)
□ Buttocks (glúteo)
□ Thighs (muslo)
□ Lower leg (pierna abajo)
□ Foot (pie)
□ Toes (dedos de los pies)

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

□ Pain (dolor)
□ Numbness (dormido)
□ Tingling (hormiguero)

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

□ Sitting (sentado)
□ Standing (parado)
□ Driving (manejando)
□ Bending (flexión)
□ Lifting (levantando cosas)
□ Head movement (movimiento de la cabeza)
□ Arm movement (movimiento del brazo)
□ Lying on side (acostado de lado)
□ Lying on stomach (acostado de estomago)
□ Lying on back (acostado de espalda)

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

□ Asprin/Tylenol (Aspirina/ Tylenol)
□ Ibroprofen
□ Pain pills (pastillas para el dolor)
□ Muscle relaxers (relajantes musculares)
□ Massage (masaje)
□ Heat (calor)
□ Cold (helado)
□ Rest (descanso)
□ Exercise (ejercicio)
□ 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)