WELLNESS DALLAS
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NEW PATIENT PACKET

1. PATIENT INFORMATION

DATE:____/______/______

NAME:____
LAST FIRST M. INITIAL

ADDRESS:____

____

HOME PHONE #: (   ) ______________-______________

WORK PHONE #: (   ) ______________-______________

CELL PHONE #: (   ) ______________-______________

E-MAIL: ____

SEX: ☐ FEMALE ☐ MALE DOB:_____/______/_________

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SOCIAL SECURITY #: __________-__________-__________

OCCUPATION: ____

EMPLOYER: ____

EMPLOYER ADDRESS: ____

____

EMPLOYER PHONE #: (   ) ____________- _______________

HOURS WORKED PER WEEK: ______________________________
IN CASE OF AN EMERGENCY:

NAME:______________________________ RELATION: ______________________

PHONE#: (   ) ___________ -______________

IS CONDITION DUE TO AN ACCIDENT? ☐YES ☐ NO
☐ AUTO (COMPLETE SECTION 3)
☐ WORK/HOME/OTHER (COMPLETE SECTION 4)

PRIMARY PHYSICIAN: ____

PHONE # (   ) ______________-___________________

2. INSURANCE INFORMATION

HEALTH INSURANCE: (PRIMARY)

INS CO: ________________________PHONE#:(   )___________-___________

POLICYHOLDER NAME: ____

POLICYHOLDER DOB:____

RELATIONSHIP OF POLICYHOLDER:____

POLICY # :______________________________ GROUP#: ________________________

HEALTH INSURANCE: (SECONDARY)

INS CO: _________________________PHONE#: (   ) __________-___________

POLICYHOLDER NAME: ____

POLICYHOLDER DOB:____

RELATIONSHIP OF POLICYHOLDER:____

POLICY # :______________________________ GROUP#: ________________________

COMPLETE THE FOLLOWING IF INJURY IS RELATED TO AN AUTO ACCIDENT

MOTOR VEHICLE INSURANCE:

INS CO: __________________________PHONE#:(   )-___________-__________

POLICY # ____

CLAIM#: ____

FAX#: ______________________________________ PIP MAX:___________________

HAVE YOU RETAINED AN ATTORNEY?

☐ **YES** ☐ **NO**

NAME: ____

PHONE#: (   ) - ______________- __________________

3. AUTO ACCIDENT INFORMATION (IF APPLICABLE)

DATE OF INJURY: _____/_____/______ TIME: ____:____ AM/PM STATE: _____ WERE YOU THE: ☐ DRIVER ☐ PASSENGER SEATED: ☐ FRONT ☐ BACK

DESCRIBE IN DETAIL HOW YOUR INJURY OCCURRED: ____

WERE YOU STRUCK FROM: ☐ BEHIND ☐ FRONT ☐ LEFT SIDE ☐ RIGHT SIDE WERE YOU WEARING A SEATBELT: YES / NO

DID YOU BRACE FOR IMPACT: YES / NO

DID YOU KNOW YOU WERE GOING TO BE HIT?: YES / NO SPEED OF YOUR VEHICLE: _________MPH SPEED OF OTHER VEHICLE: ________MPH

MAKE & MODEL OF YOUR VEHICLE: _____________________________________ **MAKE & MODEL OF OTHER VEHICLE:**____

WERE THE POLICE NOTIFIED? YES / NO DID POLICE FILE A REPORT?: YES / NO APPROXIMATE DAMAGE TO VEHICLE: $________________________

4. INJURY INFORMATION

DATE OF INJURY: _____/______/_______ TIME: ________:__________ AM / PM DID YOU GO TO THE HOSPITAL AFTER THE ACCIDENT? YES / NO

WHICH HOSPITAL: ____CITY:__________________________STATE:____________

HAVE YOU HAD X-RAYS, MRI'S OR CT SCANS SINCE THIS ACCIDENT? YES / NO IF YES, WHICH ONES? ______________________________

____

PLEASE LIST ANY PRESCRIBED MEDICATION SINCE THE ACCIDENT: ____

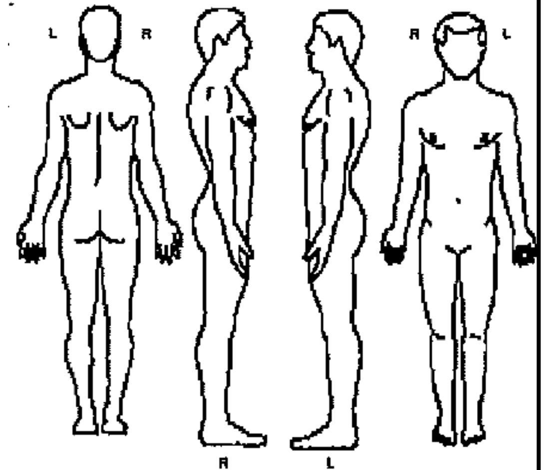
____

5. CURRENT COMPLAINTS

WHAT ARE YOUR PRESENT COMPLAINTS?: ____

____.

USE AN "X" ON THE DRAWING TO MARK WHERE YOU ARE EXPERIENCING PAIN (OR OTHER SYMPTOMS).



WHEN DID YOUR SYMPTOMS FIRST APPEAR: ____

DO YOUR SYMPTOMS INTERFERE WITH: ☐ SLEEP ☐ DAILY ROUTINE ☐ WORK ☐ RECREATION

ARE YOU WORKING LESS HOURS / DAYS AS A RESULT OF YOUR INJURIES? YES / NO

IF YES, PLEASE EXPLAIN ____

____

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM:

☐ SITTING ☐ STANDING ☐ WALKING ☐ BENDING ☐ LYING DOWN

HOW WOULD YOU RATE YOUR SYMPTOMS: ☐ MILD ☐ MODERATE ☐ SEVERE

HOW WOULD YOU RATE YOUR CURRENT SYMPTOMS: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
NO SYMPTOMS WORST POSSIBLE

SINCE THE ACCIDENT, ARE YOUR SYMPTOMS: ☐ IMPROVING ☐ UNCHANGED ☐ WORSENING

6. HOSPITALIZATION /EXAMINATION HISTORY

HAVE YOU BEEN IN THE HOSPITAL FOR ANY OTHER CONDITION? YES / NO IF YES, NAME OF HOSPITAL: ____________________________

WHEN DID YOU GO? _______/________/________ HOW DID YOU GET THERE? ______________________________________

WERE YOU PRESCRIBED MEDICATION: YES / NO IF YES, WHAT MEDICATIONS? ______________________________________

HAVE YOU SEEN ANY OTHER DOCTOR OR RECEIVED ANY OTHER TREATMEANT FOR YOUR CURRENT CONDITION? ____________________

IF YES, EXPLAIN: ____

DOCTOR'S NAME AND ADDRESS: ____

PHONE #: (   ) ________-___________ DATE(S) SEEN: ___________________________ DIAGNOSIS: ______________________________

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED:

TEST	REGION	DATE
EXAMINATION	______________________	__________________
MRI/CT	______________________	__________________

7. HEALTH HISTORY/INJURIES/TREATMENT

INJURIES YOU HAVE HAD IN THE PAST: DESCRIPTION: DATES:

AUTO ACCIDENT(S): ____________________

WORK INJURIES: ____________________

BROKEN BONES: ____________________

OTHER: ____________________

HAVE YOU BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: (PLACE AN "X" IN BOXES THAT APPLY)

- ☐ Muscle disorder
- ☐ Nervous System Disorder
- ☐ Bone Disorder
- ☐ Rheumatoid Arthritis
- ☐ Allergies
- ☐ HIV
- ☐ Gallbladder
- ☐ Diabetes
- ☐ Depression
- ☐ Coughing Blood
- ☐ Stomach, Intestines (GI)
- ☐ Lungs, Asthma
- ☐ Broken Bones
- ☐ Eating Disorder
- ☐ Pace Maker
- ☐ Seizures/Convulsions`
- ☐ A Congenital Disease
- ☐ Excessive Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney, Bladder (GU)
- ☐ Circulatory Problems
- ☐ Osteoarthritis
- ☐ Epilepsy
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Strokes
- ☐ Cancer
- ☐ Ulcer
- ☐ Hernias
- ☐ Ears, eyes, nose, throat
- ☐ Tumors
- ☐ Heart Disease

SURGERIES YOU HAVE HAD FOR THIS CONDITION: DATES:

SPINE SURGERIES ☐ DISCECTOMY ☐ LAMINECTOMY ☐ FUSION ☐ OTHER:____________________ ____________________

OTHER SURGERIES: ____________________ ____________________

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION:

☐ MEDICATION ☐ INJECTIONS ☐ PHYSICAL THERAPY
☐ MASSAGE ☐ CHIROPRACTIC ☐ ACUPUNCTURE
☐ OTHER:____________________

LIST ALL MEDICATIONS: ____________________

FEMALE PATIENTS' START DATE OF MOST RECENT MENSTRUAL CYCLE:____________________ ARE YOU CURRENTLY PREGNANT?: ____________________

8. YOUR DOCTORS

PRIMARY/ FAMILY DOCTOR: ____________________ PHONE #:( ) __________ -__________

ORTHOPEDIC DOCTOR: ____________________ PHONE # :( ) __________ -__________

PAIN MANAGEMENT DOCTOR: ____________________ PHONE #: ( ) __________ -__________

NEUROLOGIST: ____________________ PHONE #: ( ) __________ -__________

CHIROPRACTOR: ____________________ PHONE #: ( ) __________ -__________

9. PATIENT INFORMATION

MEDICATIONS CURRENTLY TAKING	ALLERGIES

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Informed Consent for Chiropractic Treatments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the chiropractor named above and/or other licensed doctors of chiropractic who now or in the future, treat me while employed by, working or associated with or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below.

I have had an opportunity to discuss with the chiropractor named below and clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that as in the practice of medicine, in the practice of chiropractic, there are some risks of treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risk and complications and wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its consent and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand the above information and hereby authorize *James N Kontaratos/Wellness Dallas/Advanced Chiropractic North* to prescribe and provide treatment.

______________________________________ ______________________________________
(Please Print) **(Witness)**

______________________________________ ______________________________________
(Signature) **(Date)**

____
(Date)

Consent to treat a Minor Child

The information I have given this office pertaining to ___________________________________ is truthful and complete to the best of my knowledge.

________ I authorize the doctor and staff of Advanced Chiropractic North to administer such procedures and treatment as they deem necessary to my son/daughter/ward in legal custody. The doctor has implied no guarantee of cure.

________ I authorize the doctor and staff of Advanced Chiropractic North to treat the above minor without a parent or guardian present.

______________________________________ ______________________________________
(Please Parent or Guardian Name) **(Witness)**

______________________________________ ______________________________________
(Parent or Guardian Signature) **(Date)**

______________________________________ ______________________________________
(Relationship to Minor Child) **(Date)**

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Partial Assignment of the Cause of Action, Assignment of Proceeds, Contractual Lien, & Authorization

I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities (a payer), which may keep, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of Advanced Chiropractic North ("Advanced Chiropractic North") in the amount of full charges incurred by me at the office, past or future, including, but not limited to, charges for treatment, narrative reports, dispositions, testimony, and any other charges incurred by me at the office ("my charges") . I further grant a contractual lien to Advanced Chiropractic North with respect to my charges, however, I understand that nothing in this Agreement shall be construed as an election by Advanced Chiropractic North to claim protection under any motorist coverage, liability coverage, property damage coverage, and malpractice coverage.

I further agree that, in the event a payer refuses to pay Advanced Chiropractic North, I hereby assign to the office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to Advanced Chiropractic North as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to Advanced Chiropractic North for my charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of the office. I further direct (and the Office hereby requests), each attorney to provide immediate notice to the Office regarding my funds received by the attorney relating to my accident, to promptly pay the office out of such funds, and to provide a full accounting of such funds to the Office upon its request.

I hereby authorize and direct Advanced Chiropractic North to file my claims with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance of payment (e.g., liability, med pay, attorneys, etc.); I hereby authorize and direct Advanced Chiropractic North to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment..

I hereby direct all peers to release to Advanced Chiropractic North any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release my information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I hereby direct this Office to file a copy of this agreement, together with my applicable charges, with any and all payers, regardless of whether a claim has been established with said payers. I hereby authorize Advanced Chiropractic North to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment for balances on charges incurred by me to any other outstanding bills still owed by my spouse, my dependents, regardless of whether these other charges are related to my condition or me.

I understand that I remain personally responsible for the total amounts due to Advanced Chiropractic North for these services. This agreement does not constitute any consideration for this Office to await payments. It may demand payments from me immediately and I am responsible for payment and will reimburse Advanced Chiropractic North Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of Advanced Chiropractic North and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office, to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is responsibly necessary for the protection of the rights and interest of Advanced Chiropractic North and me. However, should any provision of this agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any part hereto, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Patient Name (Please Print): ____

Patients Signature: ____________________________ Date: ____________________

Parent/Guardian's Signature: ____

Staff Witness Signature______________________________ Date_________________