Rockwall Elite HEALTHCARE

105 N Goliad St.
Rockwall, TX 75087
Ph: 972-961-0673 FAX: 972-551-4888
Email: Rockwallelitehealthcare@gmail.com

New Patient Information

Name (Last, First, MI):_____ **Date**: _____

DOB: _____ **Age**: _____ **Sex**: _____ **Gender**: _____ **SS* #** _____-_____-_____

*This will only be used for processing insurance claims and will be kept secure, confidential, and compliant with HIPPA privacy standards.

Address: _____ **City**: _____ **State**: _____ **Zip**_____

Cell Phone: _____ **Home Phone**: _____

Email: _____ **@ gmail.com yahoo.com hotmail.com** _____**.com**

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Minor

Name of Spouse: _____ **Spouses Phone**: _____

Emergency Contact (if other than spouse): _____ **Phone Number**: _____

Relationship: _____ **Occupation**: _____

Primary Insurance: _____ **Member ID #**: _____

Name of Policyholder: _____ **Policyholder's DOB**: _____

Self Spouse Parent Other

What is the reason for your visit today? _____

Have you been treated for this condition before? Yes No

If so, when and how?_____

Results: _____

Is this visit due to an accident or injury? Yes No If yes, what type? _____

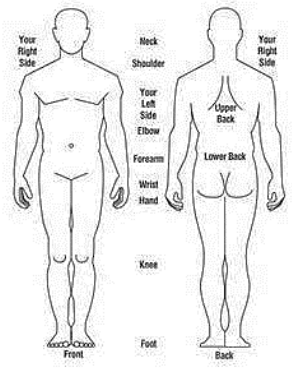
How did you hear about our practice? (Circle One)

Internet/Social Media/Search Engine (Specify): _____

Referral from friend/family? (Specify): _____

Other (Specify): _____

Draw on the diagram below where you have pain/symptoms:



Rate your pain on a scale from 0-10: (0 is NO pain at all, 10 being the worst you have EVER had)

0 1 2 3 4 5 6 7 8 9 10

How often are you experiencing your symptoms?

_____ Constantly (76-100% of the time) _____ Frequently (51-75% of the time)
_____ Occasionally (26-50% of the time) _____ Intermittently (1-25% of the time)

How would you describe your type of pain? (Circle most accurate)

Sharp Deep Ache Burning Shooting Numbness Stiff Tingly Dull
Radiating up/down If so, where? _____

What have you found that makes it better or worse if anything? _____

Are your symptoms getting better, worse or staying the same? _____

How long have you had this problem? _____

What do you think caused this problem? _____

Does it prevent you from doing any activities? _____

Has the problem interfered with your work? If so, specify the severity.

Not at all A little bit Moderately Quite a bit Extremely

Has your problem interfered with your social/family activities?

Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for your problem? (Circle all that apply)

Neurologist Primary Care Physician Orthopedist Massage Therapist Chiropractor
Other: _____

Have you ever been adjusted by another chiropractor? YES NO

Doctor's Name: _____ **Approx. Date of Last Visit:** _____

What type of exercise would you say you do?

Strenuous Moderate Light None

Do you or any of your immediate family members have any of the following:

Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS

Allergies: _____ No Known Drug Allergies _____ Other: _____

Please list any medical conditions that you have: _____

Please list any surgeries and/or hospitalizations that you have had in the past (<u>type & approx. date</u>):

_____

_____

Please list any/all medications, supplements/vitamins, herbs etc. you are currently taking:

Name	Strength	Dose	Why are you taking it?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For each of the conditions listed below please circle if you have experienced them in the last <u>six</u> months:

Neck Pain	Diabetes	Headaches	Chest Pains	Loss of Bowel
Bladder	Upper Back Pain	Heart Attack	Cancer	Low Back Pain
Asthma	Ringing in the ears	Shoulder Pain	Stroke	Visual Disturbances
Elbow Pain	Angina	Dizziness	Upper Arm Pain	Kidney Stones
Wrist Pain	Abdominal Pain	Hand Pain	Hip Pain	Gall Bladder Issues
Constipation	Excessive Thirst	Ankle/Foot Pain	Leg Pain	
Sexual Dysfunction	Jaw Pain	Joint Pain/Stiffness	High Blood Pressure	

X-Ray Questionnaire: (FOR WOMEN ONLY)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

_____ There is a possibility that I might be pregnant
_____ Yes, I am pregnant
_____ No, I am not pregnant

Date of your last menstrual period? _____

I request that x-rays not be taken because: _____

TO HELP US BETTER UNDERSTAND AND REACH YOUR GOALS, PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ **RELIEF CARE -** Easing the pain and discomfort you are having.
- ☐ **CORRECTIVE CARE -** Addressing the *CAUSE* of the problem, correct the *SYMPTOMS* and decrease the *RECURRENCE* of the problem.
- ☐ **DOCTOR'S RECOMMENDATIONS -** Allowing our team of doctors and medical staff to assess your needs and desires and recommend the best treatment plan.

Patient Signature: _____ **Date:** _____

*I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Please take a moment to look through our patient testimonials in our waiting area that our patients have shared with us about their experience here Rockwall Elite Healthcare. We look forward to you becoming a part of our Chiropractic family and hearing about your experience in the future to share with others!

ASSIGNMENT OF BENEFITS

FOR VALUE RECEIVED, I hereby assign to **Rockwall Elite Healthcare,** hereinafter referred to as **REH**, the extent of my bill for health care services and any claims which I may have for benefits provided under any policy of insurance or other health care plan and against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses, or health care costs.

I further hereby assign to **REH** a lien in the amount of my bill for health services against any other party whose negligence may have caused my injuries, or who may be legally responsible for my injuries, illnesses, or health care costs.

I hereby direct any payments to be made directly to **REH**. I agree to cooperate with **REH** in collecting any such amounts, including appearing in court if necessary. **REH** is further empowered to request and receive from any insurance company or health care plan all information or supporting documentation concerning or touching upon handling, calculation, processing, or payment of any claims.

All insurers and providers of health care benefits are hereby notified that this agreement is subject to the financial arrangements with **REH** as set forth below.

I recognize payment for services rendered by **REH** is due upon receipt of the services. **REH** has agreed to accept that this assignment is an accommodation to me. I understand that **REH** may revoke this assignment at any time. I hereby waive any applicable statute of limitations which may affect **REH's** right to collect for their services.

In the event I directly receive any check, draft, or other benefits subject to this assignment at a time when there is still a balance due to **REH**, I agree to deliver such check, draft, or benefits to **REH** immediately upon receipt and the proceeds thereof shall be applied to my bill.

RECORDS RELEASE

*I hereby authorize **REH** to release and to permit the examination or copying of any of my medical records, X-rays, laboratory tests, and the results of all the tests or any tape or character to such persons, as **REH** deems appropriate.*

In the event any provisions of this agreement are determined to be invalid or unenforceable, all other provisions shall remain enforceable.

IN WITNESS WHEREOF, Agreement has been entered into on the day and year set forth below.

_____ _____

{Print Name} **{DOB}**

_____ _____

{Signature} **{Date}**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Rockwall Elite Healthcare

I acknowledge that I have read the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

{Print Name}

_____

{Signature} **{Date}**

Office Use Only

Rockwall Elite Healthcare attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because of the following:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency prevented us from obtaining acknowledgment
- ☐ Other _____

_____ _____

{Staff Signature} **{Date}**

INFORMED CONSENT TO TREATMENT

ROCKWALL ELITE HEALTHCARE

Physicians, Chiropractors, Osteopaths, and Physiotherapists using manual manipulation are required by law to advise their patients of the following information:

1. With neck problems, there have been extremely rare incidents of injury to the vertebral artery during treatment. These have caused strokes or stroke-like symptoms which are usually temporary. The chances of this happening are extremely rare (*approximately 2 in 1 million treatments*).

2. With neck or back problems, there have been extremely rare incidents of rib separation or fracture. More common symptoms include pain, bruising, swelling, or aggravation of symptoms.

APPROPRIATE TESTS WILL BE PERFORMED TO MINIMIZE ANY POSSIBLE RISKS.

I, the undersigned, do hereby consent to any chiropractic and medical treatment performed on me by the licensed medical professionals of Rockwall Elite Healthcare that has been indicated and explained to me. If during treatment unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and treatments that are indicated by sound and prudent chiropractic and medical practices which may require additional x-rays, chiropractic, medical, orthopedic, neurological, laboratory, and/or consulting with another doctor.

No guarantee or warranty has been made to me that results will be to my complete satisfaction.

If you have further questions, please consult with your doctor.

BY SIGNING BELOW, I CONFIRM THAT I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION AND GIVE MY CONSENT TO TREATMENT.

_____

{Signature} **{Date}**

_____

{Witness}

CONSENT TO TREAT A MINOR

By signing below, I certify that I am the legal parent/guardian of the patient and authorize the licensed medical professionals at Rockwall Elite Healthcare to administer chiropractic and/or medical care as deemed necessary.

_____

{Child's Name} **{Date}**

_____

{Signature of Parent/Guardian}