



*dr. nataly perez*

CHIROPRACTOR + ACUPUNCTURIST

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NEW PATIENT INFORMATION:

Today's Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Age: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Preferred Phone #:  Home  Cell Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

MEDICAL HISTORY

Have you been treated for any conditions in the last year?  YES  NO

If yes, please describe: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Date of last x-rays: \_\_\_\_\_ Where? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

What vitamins, minerals, herbs, or special diets do you currently take? \_\_\_\_\_

MEDICAL/FAMILY HISTORY

Have you ever:

If yes, briefly explain below.

- Had broken bones?       YES     NO \_\_\_\_\_
- Been hospitalized?       YES     NO \_\_\_\_\_
- Been in an auto accident?     YES     NO \_\_\_\_\_
- Had sprains/strains?       YES     NO \_\_\_\_\_
- Had surgery?               YES     NO \_\_\_\_\_

FAMILY HISTORY

Do any family members have any present or past health conditions that may concern your health?  
Please describe below. (Example: heart disease, diabetes, cancer, arthritis, etc.)

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Tell us about your exercise habits:

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CURRENT COMPLAINT

Date of Injury: \_\_\_\_\_ Date of Symptoms: \_\_\_\_\_

Please describe your present major complaints: \_\_\_\_\_ Pain Scale 0-10 (10 being the worst)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Have you had this condition in the past?  YES  NO

If yes, how was it treated? \_\_\_\_\_

Have you had chiropractic care in the past?  YES  NO

If yes, who? \_\_\_\_\_

Have you had physical therapy in the past?  YES  NO

If yes, what kind? \_\_\_\_\_

Does anything make the pain better? \_\_\_\_\_

Does anything make the pain worse? \_\_\_\_\_

Do you have pain every day?  YES  NO      Is it constant?  YES  NO

Do your symptoms interfere with daily life?  YES  NO

Does your pain wake you up at night?  YES  NO

When is your pain worse? (Example: morning, night, work hours) \_\_\_\_\_

Does change in weather effect your pain?  YES  NO

Any other information you would like to share:

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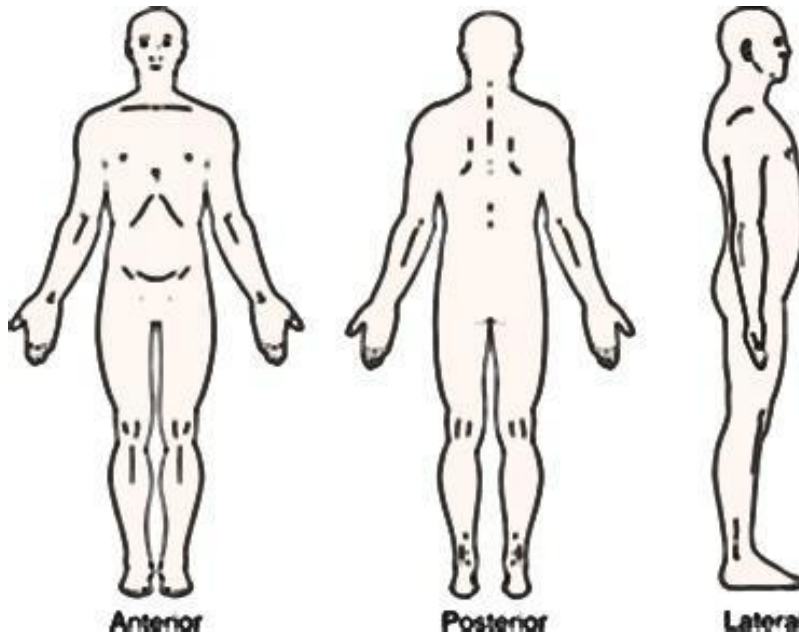
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Have you ever suffered from any of the following?

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Allergies	<input type="checkbox"/> Eye Pain or Difficulties	<input type="checkbox"/> Polio
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Sleep Problems/Insomnia
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Spinal Curvatures
<input type="checkbox"/> Cancer	<input type="checkbox"/> Irregular Cycle	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chest Pain/Conditions	<input type="checkbox"/> Kidney Infection	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Swollen Joints
<input type="checkbox"/> Constipation	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Thyroid Conditions
<input type="checkbox"/> Cramps	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Depression	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Other:
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Other:
<input type="checkbox"/> Ears Ringing	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A = Ache      B = Burning      N = Numbness      O = Other      P = Pins & Needles      S = Stabbing



I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges, but that I will be informed of any charged services before they are performed.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO TREAT MINOR CHILD

I hereby authorize Nataly Perez, DC, LLC and its providers and staff to administer a physical examination and treatment as it deems necessary to the patient listed at the top of this page. I am legally authorized to sign this consent.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO RELEASE INFORMATION

I understand and have been provided with a Notice of Privacy Practices that provides a complete description of my health information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Nataly Perez, DC, LLC reserves the right to change their notice and practices.

I understand that I may revoke this consent in writing, except to the extent that Nataly Perez, DC, LLC has already taken action in reliance thereon.

I consent to the use and disclosure of my health information for treatment, payment, and healthcare procedures as described in the Notice of Privacy Practices.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities ("payers"), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, or injuries, or illnesses, past, present, or future, to pay directly and exclusively in the name of Nataly Perez, DC, LLC such sums as may be owed said offices for charges incurred by me at the office relating to my condition ("charges"), with such payment to be made exclusively in the name of Nataly Perez, DC, LLC.

For the purposes of this document herein ("assignment"), "proceeds" shall include, but not be limited to, monies/proceeds from any settlement, judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to office any information regarding my coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Nataly Perez, DC, LLC to endorse/sign my name on any and all checks listing me as payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZATION TO TEXT/CALL/EMAIL

I recognize that communication done electronically does not have any guarantee of privacy, however due to convenience and timing, communications might be necessary by electronic means of email, fax, and text. I consent to communications specified below. Should I wish to withdraw consent below I will notify the doctor/clinic in writing of the withdrawal of consent.

I, \_\_\_\_\_ do hereby authorize the office of Dr. Nataly Perez to communicate with me via

- Text at the phone number \_\_\_\_\_
- Fax: \_\_\_\_\_
- Email: \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO SHARE MEDICAL INFORMATION**

I would like to authorize the following person/s to be able to:

- Make or cancel appointments for me
- Pick up medical records
- Have access to my medical records

I authorize:

Name of designated person/s: \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**LATE CANCELLATION/NO SHOW POLICY**

I understand that I have until 8am of the day of my appointment to cancel without penalty. Cancellations can be made via text, email, phone call, or voicemail messages.

In the case of an emergency, penalty charges may be waived. Late cancellation/no show fee is \$30.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_