dr. nataly perez

CHIROPRACTOR + ACUPUNCTURIST

373 ½ West 19th, B2, Houston, TX 77008 | Ph: 832-498-2236 | Fax: 888-811-8540

NEW PATIENT INFORMATION:

☐ Male ☐ Female Today's Date: _____

First Name: _____ Last Name: _____ Age: _____

Address: _____City, State, Zip _____

Home #: _____Cell #: _____Work #: _____

Preferred Phone #: ☐ Home ☐ Cell ☐ Work Email: _____

Social Security # _____-_____-_____ Date of Birth: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Your Occupation: _____ Employer:_____

How did you hear about our office? _____

Please contact me via: EMAIL PHONE TEXT Please circle all that apply.

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.)

_____

_____

_____

_____

HABITS

	None	Light	Moderate	Heavy		None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐	Water	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	Salty Foods	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	Sugary Foods	☐	☐	☐	☐
Drugs	☐	☐	☐	☐	Artificial Sweeteners	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐
Appetite	☐	☐	☐	☐					
Soft Drinks	☐	☐	☐	☐					

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, who? _____

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 affect your pain? ☐ YES ☐NO

Any other information you would like to share:

_____

_____

_____

_____

_____

_____

_____

_____

_____

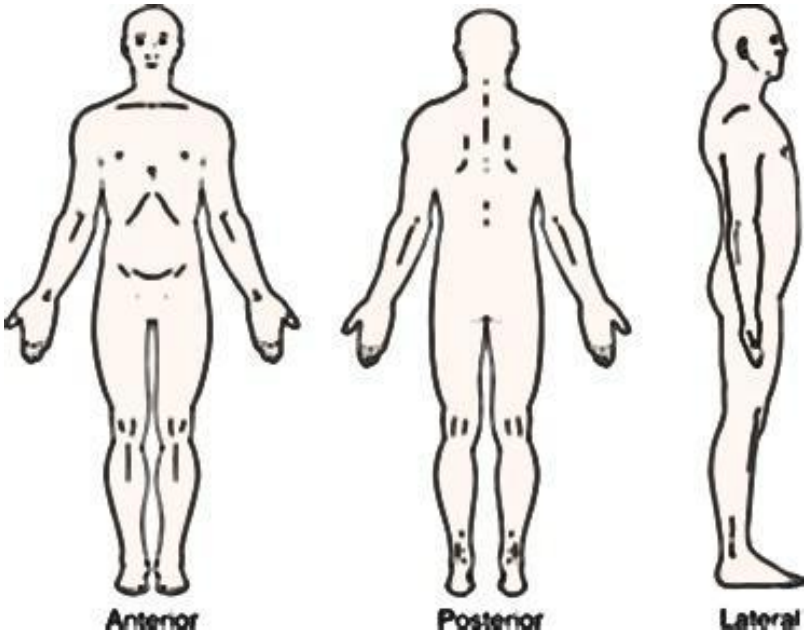
_____

Have you ever suffered from any of the following?

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