Las Colinas Highland Park

Spine & Sports Medicine

Patient Information

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt No: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) - _____ - _____ Work Phone: (_____) - _____ - _____

Alternate Phone: (_____) - _____ - _____ Cell/Pager: (_____) - _____ - _____

Email: _____

Age: _____ Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Social Security No.: _____ / _____ / _____ Driver's License (state and Number): _____

Employer/Name of School: _____ ☐ Full Time ☐ Part Time

If Applicable:

Spouse's Last Name: _____ First Name: _____ Middle Initial: _____

Spouse's Work Phone: (_____) - _____ - _____ Social Security No.: _____ / _____ / _____

Responsible Party Information *(if different than above)*

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Address: _____ Apt No: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) - _____ - _____ Work Phone: (_____) - _____ - _____

Cell/Pager: (_____) - _____ - _____ Social Security No.: _____ / _____ / _____

Patient Insurance Information *(Please present insurance card to receptionist)*

PRIMARY Insurance Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance ID No.: _____ Group No.: _____

SECONDARY Insurance Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Patient Information

Name of Insured: _____

Relationship to Insured: ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

Insurance ID No.: _____ Group No.: _____

Medicare Number: _____ Medicaid Number: _____

Patient Referral Information

Referred By: _____

Other physicans who care for you: _____

_____

Emergency Contact

Last Name: _____ First Name: _____ Relationship: _____

Address: _____ Apt No: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) - _____ - _____ Work Phone: (_____) - _____ - _____

Alternate Phone: (_____) - _____ - _____ Cell/Pager: (_____) - _____ - _____

❑ I authorize the attending physican to release my medical information for consultation, referral, or insurance processing purposes.I authorize my insurance company(ies) to pay benefits directly to the physican.

Patient Signature: _____ Date: _____ / _____ / _____

Payment is due at the time services are rendered.

As a courtesy we will your insurance so that you may be reimbursed.

Las Colinas Highland Park

Spine & Sports Medicine

Patient's Present Complaints

Patient Name: _____

Present Complaints: _____

Who is your primary care physician (PCP)?: _____

Please list your symptoms in order of severity: _____

_____

How did your problem begin?: _____

Date problem began: _____/_____/_____

What treatments have you undergone for this condition in the past? (surgery,medications, injections,therapy, chiropractic): _____

_____

Have you had X-rays,MRI or other tests for this condition? ❑ YES ❑ NO If yes, what tests and when? _____

_____

Is this condition the result of an auto or work accident? ❑ YES ❑ NO If yes, please explain: _____

_____

How bad is your pain?(circle a number): 0 1 2 3 4 5 6 7 8 9 10

No Pain *Unbearable Pain*

How often are your symptoms present?	❑ Constantly	❑ Frequently	❑ Occasionally	❑ Intermittently		
Describe your *current* pain/symptoms:	❑ Sharp/Stabbing	❑ Throbbing	❑ Aches	❑ Dull	❑ Soreness	❑ Weakness
	❑ Numbness	❑ Shooting	❑ Gripping	❑ Burning	❑ Tingling	
	❑ Other: _____					
Since it began, is your problem:	❑ Improving	❑ Getting	❑ Worse	❑ No Change		
What makes the problem better?	❑ Nothing	❑ Lying Down	❑ Walking	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ Inactivity/Rest	❑ Other _____			
What makes the problem worse?	❑ Nothing	❑ Lying Down	❑ Walking	❑ Standing	❑ Sitting	❑ Movement
	❑ Exercise	❑ Inactivity/Rest	❑ Other _____			
Can you perform your daily home activities?	❑ Yes	❑ Yes,only with help	❑ Not at all			
Do you exercise?	❑ Yes,almost daily	❑ Yes, occasionally	❑ Not at all			
Describe your job requirements:	❑ Mainly sitting	❑ Light labor	❑ Heavy labor			
Does your job include working with computers?		❑ Yes ❑ No				
Can you perform your daily work activities?	❑ Yes, all activities	❑ Only some	❑ Not at all			
Describe your stress level:	❑ None to mild	❑ Moderate	❑ High			

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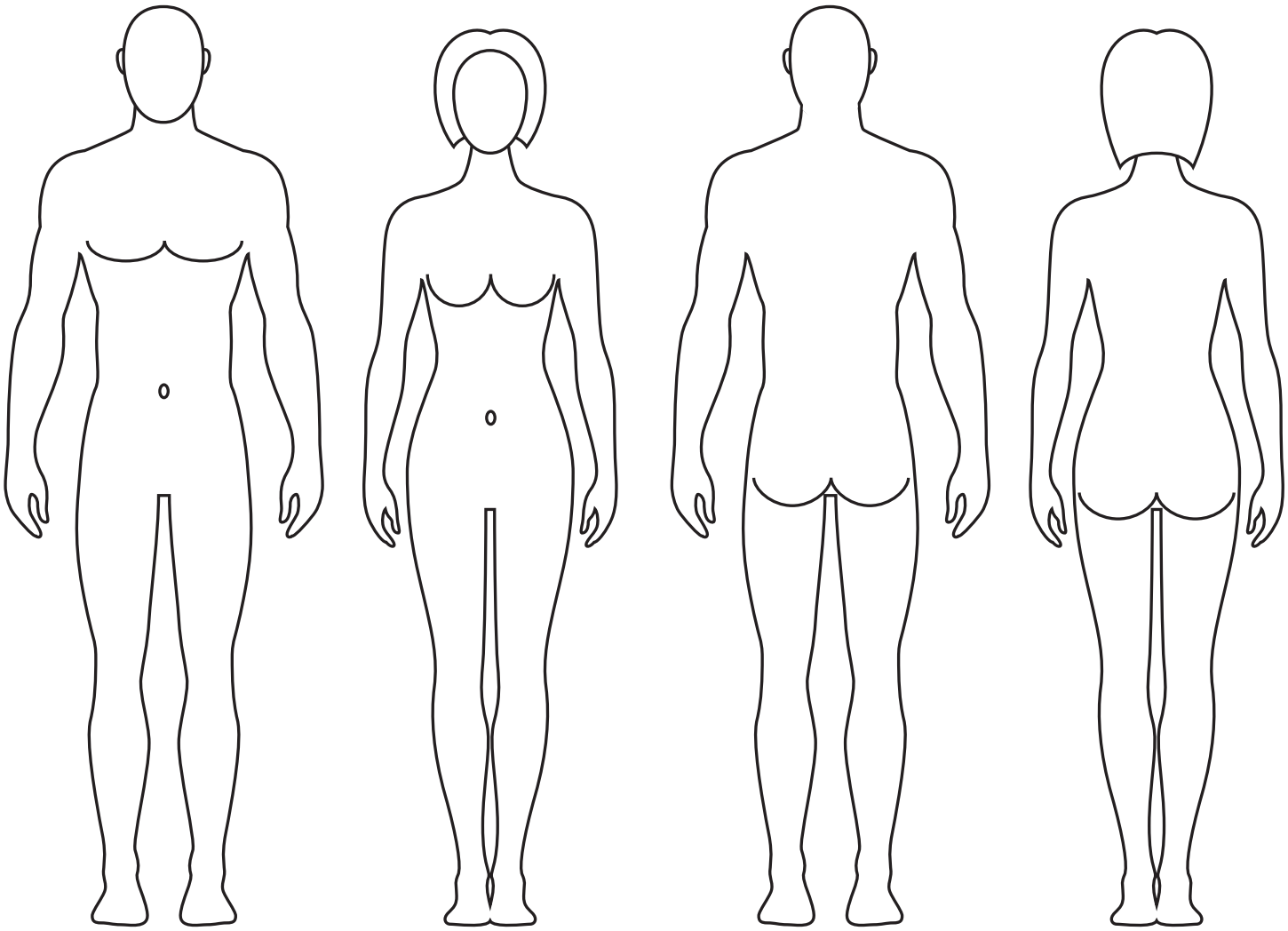
Patient's Present Complaints



Mark an X on the pictures where you have pain or other symptoms; include symptoms of pain, numbness or tingling.

Patient's signature: _____ Date: _____ / _____ / _____

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Patient Medical History

Patient Name: _____

FEMALES ONLY:

Are/or could you be pregnant?
❑ No ❑ Yes

Are you nursing?
❑ No ❑ Yes

Do you have breast implants?
❑ No ❑ Yes

Due date_____

SURGERIES:

❑ No Surgeries ❑ Appendectomy ❑ Broken Bone ❑ Cancer Treatment ❑ Cardiovascular Procedure
❑ Cervical Disc Procedure ❑ Gastric Bypass ❑ Hysterectomy ❑ Joint Replacement ❑ Laminectomies
❑ Lumbar Disc Procedure ❑ Mastectomy ❑ Prostate Surgery ❑ Cancer Treatment ❑ Breast Reduction
❑ Other: _____

MEDICAL CONDITIONS:

❑ No Medical Conditions ❑ Arthritis ❑ Cancer ❑ Diabetes ❑ Heart Disease
❑ Hepatitis B ❑ Hypertension ❑ Skin Disorder ❑ Stroke ❑ Other:
_____

ALLERGIES:

❑ No Known Allergies ❑ Eggs ❑ Fish And Shelfish ❑ Latex Or Adhesives ❑ Medications
❑ Milk Or Lactose ❑ Peanut ❑ Penicillin ❑ Soy ❑ Sulfites
❑ Wheat/Gluten ❑ Other: _____

SOCIAL HISTORY:

❑ Caffeine Used Occasionally ❑ Caffeine Used Often ❑ Chew Tobacco ❑ Drink Alcohol Occasionally ❑ Drink Alcohol Often
❑ Exercise Not At All ❑ Exercise Occasionally ❑ Exercise Often ❑ Experience Stress Ocasionally ❑ Experience Stress Often
❑ Smoke 1 Pack or Less Per Day ❑ Smoke More Than 1 Pack Per Day ❑ Wear Seatbelts Always ❑ Wear Seatbelts Never ❑ Wear Seatbelts Usually

FAMILY HISTORY:

❑ No Family History ❑ Autoimmune Disease ❑ Arthritis ❑ Cancer ❑ Cholesterol
❑ Chronic Back Pain ❑ Chronic Headaches ❑ Diabetes ❑ Heart Problems ❑ High Blood Pressure
❑ Osteoporosis ❑ Psychiatric ❑ Stroke ❑ Thyroid
❑ Who: _____

OCCUPATIONAL ACTIVITIES:

❑ Administration ❑ Business Owner ❑ Construction ❑ Computer User ❑ Daycare/Childcare
❑ Electrical/Secreterial ❑ Executive/Legal ❑ Food Service ❑ Food Service Industry ❑ Healthcare
❑ Heavy Equipment Operator ❑ Home Service ❑ Household ❑ Manual Labor ❑ Manufacturing
❑ Military ❑ Police ❑ Police/Fire ❑ Professional Athlete ❑ Retail Worker
❑ Retired ❑ Student ❑ Teacher ❑ Technology ❑ Truck Driver
❑ Flight Attendent ❑ Other: _____

RECREATIONAL ACTIVITIES:

❑ Backpacking ❑ Basketball ❑ Biking ❑ Boating/Crew ❑ Dance
❑ Football ❑ Golf ❑ Horse Back Riding ❑ Martial Arts ❑ Racket Ball
❑ Running ❑ Skiing ❑ Soccer ❑ Swimming ❑ Tennis
❑ Walking ❑ Weight Lifting ❑ Other

EXERCISE CLASSES:

❑ Zumba ❑ Cross Fit ❑ Yoga ❑ Pilates/Barre ❑ Spin
❑ Other: _____

Patient Signature: _____ Date: _____ / _____ / _____

Doctor's Signature: _____ Date: _____ / _____ / _____

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Review of Systems

Patient Name: _____

Cardiovascular:

	Present	Past	No
Aortic Aneurism	❑	❑	❑
Cardiac Catheter	❑	❑	❑
Chest Pain	❑	❑	❑
Poor Circulation	❑	❑	❑
Heart Attack	❑	❑	❑
High Blood Pressure	❑	❑	❑
High Cholesterol	❑	❑	❑
Heart Disease	❑	❑	❑
Irregular Heartbeat	❑	❑	❑
Jaw Pain	❑	❑	❑
Pace Maker	❑	❑	❑
Swelling or Legs	❑	❑	❑
Vascular Disease	❑	❑	❑

Genitourinary:

	Present	Past	No
Blood in Urine	❑	❑	❑
Burning Urination	❑	❑	❑
Frequent Urination	❑	❑	❑
Kidney Disease	❑	❑	❑
Kidney Stone	❑	❑	❑
Lower Side Pain	❑	❑	❑

Hematologic/Lymphatic

	Present	Past	No
Blood Clots	❑	❑	❑
Cancer	❑	❑	❑
Easy Bruising	❑	❑	❑
Easy Bleeding	❑	❑	❑
Fevers/Chills/Sweats	❑	❑	❑
Hepatitis	❑	❑	❑

Respiratory:

	Present	Past	No
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Cold/Flu	❑	❑	❑
Cough/Wheezing	❑	❑	❑
Emphysema	❑	❑	❑
Pneumonia	❑	❑	❑
Shortness of Breath	❑	❑	❑
Tuberculosis	❑	❑	❑

Ears/Nose/Throat:

	Present	Past	No
Bleeding Gums	❑	❑	❑
Difficulty Swallowing	❑	❑	❑
Dizziness/Vertigo	❑	❑	❑
Hearing Loss	❑	❑	❑
Nosebleed	❑	❑	❑
Ringing in Ears	❑	❑	❑
Sinus Infection	❑	❑	❑
Sore Throat	❑	❑	❑
Swollen Glands	❑	❑	❑

Eyes:

	Present	Past	No
Blurred Vision	❑	❑	❑
Cataracts	❑	❑	❑
Double Vision	❑	❑	❑
Glaucoma	❑	❑	❑
Loss of Vision	❑	❑	❑

Integumentary:

	Present	Past	No
Eczema	❑	❑	❑
Cancer	❑	❑	❑
Psoriasis	❑	❑	❑
Rashes	❑	❑	❑
Skin Disease	❑	❑	❑
Skin Lesions	❑	❑	❑
Skin Ulcers	❑	❑	❑

Allergic/lmmunologic:

	Present	Past	No
Allergy Shots	❑	❑	❑
Cortisone Use	❑	❑	❑
Hives	❑	❑	❑
HIV/AIDS	❑	❑	❑
Immune Disorder	❑	❑	❑

Gastrointestinal:

	Present	Past	No
Abdominal Pain	❑	❑	❑
Bloody Stools	❑	❑	❑
Bowel Problems	❑	❑	❑
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
Gallbladder Problems	❑	❑	❑
Liver Problems	❑	❑	❑
Nausea/Vomiting	❑	❑	❑
Poor Appetite	❑	❑	❑
Ulcers	❑	❑	❑

Musculoskeletal:

	Present	Past	No
Arthritis	❑	❑	❑
Broken Bones	❑	❑	❑
Gout	❑	❑	❑
Joints Stiffness	❑	❑	❑
Osteoporosis	❑	❑	❑
Tendinitis	❑	❑	❑
Joints Replaced	❑	❑	❑
Muscle Weakness	❑	❑	❑
Joint Pain	❑	❑	❑
Back Pain	❑	❑	❑
Neck Pain	❑	❑	❑

Endocrine:

	Present	Past	No
Diabetes	❑	❑	❑
Hair Loss	❑	❑	❑
Menopausal	❑	❑	❑
Menstrual Problems	❑	❑	❑
Thyroid Disease	❑	❑	❑

Psychiatric:

	Present	Past	No
Anxiety Disorder	❑	❑	❑
Depression	❑	❑	❑
Unusual Stress	❑	❑	❑

Constitutional:

	Present	Past	No
Change In Activity	❑	❑	❑
Difficulty Sleeping	❑	❑	❑
Energy Level Problem	❑	❑	❑
Weight Loss/Gain	❑	❑	❑

Neurological:

	Present	Past	No
Babinski	❑	❑	❑
Brain Aneurysm	❑	❑	❑
Carpal Tunnel	❑	❑	❑
Head Injury	❑	❑	❑
Meningitis	❑	❑	❑
Multiple Sclerosis	❑	❑	❑
Numbness	❑	❑	❑
Parkinson's Disease	❑	❑	❑
Pinched Nerves	❑	❑	❑
Seizures	❑	❑	❑
Severe Headaches	❑	❑	❑
Loss of Balance	❑	❑	❑
Stroke	❑	❑	❑

Present Height: _____

Present Weight: _____

Patient Signature: _____ Date: _____ / _____ / _____

Doctor's Signature: _____ Date: _____ / _____ / _____

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Las Colinas Highland Park

Spine & Sports Medicine

Financial Policy

We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our Financial Policy that we require you to read, agree to and sign prior to any treatment.

We accept Cash, Checks, Money Orders and Visa/Mastercard.

Medicare

As participating providers,we accept assignment of benefits and will file all claims for you. You are responsible for full payment of any deductible and/or co-pay and non-covered services at the time those services are rendered.

HMO/PPO and Other Managed Care

We will file all insurance claims for you. It is your responsibility to ensure your insurance company has been informed of your PCP designation and all appointments are scheduled with your PCP, except in the event ofan emergency. It is also your responsibility to present your insurance card prior to services being rendered. All co-pays and deductible are due at the time services are rendered.

Other Insurance

As a courtesy,we will your insurance claims; however, you must provide all insurance information and a completed claim form (if required) at the time of service. Please understand that your insurance policy is a contract between you and your company. We are not a party to that contract; therefore, the balance is your responsibility whether your insurance company pays or not. Payment is due in full at the time of service. If you do not wish for us to file your claims with your insurance, please notify the front desk so your account will be set up as a self pay.

U.C.R. (Usual and Customary Rate)

Our practice is committed to providing the best possible treatment and we charge what is usual and customary for our area. You are responsible for paying the bill regardless of the insurance company's determination of usual and customary rates.
EXCEPTIONS: MEDICARE, MANAGED CARE HMO and PPO.

Self Pay

Payment is due in full at the time of service.

Delinquent Accounts

Accounts that are not paid in full or satisfactory arrangements not made within 90 days of service rendered are considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau, or to an attorney for further action.

Change in Insurance, Patient Information

It is your responsibility to notify our office in the event of any change in your insurance, address, phone numbers, etc.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

☐ I have read, understand, and agree to the above Financial Policy.

Patient or Responsible Party: _____ Date: _____ / _____ / _____

Witness: _____ Date: _____ / _____ / _____

Consent of Professional Services and Release of Information

I hereby authorize Dr.Mary Collings and whomever she may designate as her assistants to administer treatment, physical examination, xray studies, laboratory procedures, chiropractic care, or any clinic services that she deems necessary in my case; and I further authorize her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the office or to the patient or a family member or employer of the patient for all or part of the office's charge, including and not limited to, hospital or medical service company, insurance companies,worker's compensation carriers,welfare funds or the patient's employer.

Patient Signature: _____ Date: _____ / _____ / _____

Las Colinas Highland Park

Spine & Sports Medicine

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations,we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information,we encourage you to ask at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, our staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office.We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractor has the right to refuse to give care.

☐ I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____ Date: _____ / _____ / _____

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Las Colinas Highland Park

Spine & Sports Medicine

Informed Consent to Chiropratic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.

2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

☐ I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

☐ I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Witness Signature

_____

Date

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Las Colinas Highland Park

Spine & Sports Medicine

Patient Medication/Supplement Information

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt No: _____

City: _____ State: _____ Zip: _____ Date Form Started: _____

Home Phone: (_____) - _____ - _____ Work Phone: (_____) - _____ - _____

Alternate Phone: (_____) - _____ - _____ Cell/Pager: (_____) - _____ - _____

Emergency Contact/Phone numbers: _____

List anything you are allergic to and describe any reaction:

_____

_____

_____

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: *Perscription and over-the-counter medications (i.e.: asprin, antacids) and herbals (i.e.: ginseng, gingko). Include medications taken as needed (i.e.: nitroglycerin).*

Date Started	Name of Medication	Dose *mg, units, drops, pulls*	When do you take it *(how many times a day, morning or night, after meals)?*	Purpose *(why do you take it)?*

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