TEXAS SPINAL CARE

Case History

Date:________________________

Name:____

Address:____

City:_________________________ State:_______________ Zip:______________________

Date of Birth:__________________ Social Security Number:________________________

Home Phone:__________________________ Cell Phone:____________________________

Work Phone:___________________________ Email:________________________________

Marital Status □M □S □D □W Sex: □M □F

Spouse's Name:___________________________ Spouse's date of birth:______________

In case of emergency, call: Name __________________________________

Relationship _____________________________

Phone # _________________________________

Employer____

Address:____

City:_________________________ State:_______________ Zip:______________________

Occupation ____

Family Medical Doctor:___________________________________ Phone: _____________________

Date of Last Visit: _________________ Date of Last Physical Examination ________________

May we have permission to update your medical doctor regarding your treatment? □ Y □ N

Purpose of this appointment: ____

Date Symptoms start: _______________________

***** How did you hear about TSC? *****

□Radio □Website □Mail ad □Magazine □TV Commercial □Massage Event

□Attorney ______________________________ □Referral___________________________________

□Other____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from any of the following:

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Osteoarthritis
__Seizures/Convulsions
__Bleeding Disorders
__High/Low Blood Pressure
__Pace Maker
__Stroke(CVA/TIA)
__Cancer
__HIV Positive
__Heartburn
__Headaches
__Malaise/Fatigue
__Skin Eruptions
__Asthma
__Diabetes
__Allergies

Have You been treated for any health condition by a physician in the last Year? □ Y □ N

If yes, please describe:____

Past Injuries

Car accidents. slips/falls, sport injuries, other (include dates)

____

____

____

Surgery

Have you had surgeries (tonsillectomy, appendectomy, dental extraction, etc) include dates.

____

____

____

Past Illness

List all previous illnesses you've had in your life____________________________________

____

____

Medications

Present prescription drugs	Past prescription drugs	Over-the-counter drugs

Therapy

Name of previous Chiropractor(s) ____

Are you presently under any therapeutic care (what type?)____________________________

What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc.)

____

Current Health

How would you describe your current health? ______________________________________

____

Exercise? ____

Vitamins? ____

Do you or any member of your family have:

	Dizziness		Nausea		Constipation		Diarrhea		Headaches
	Indigestion		Malaise		Skin Eruption		Colds		Other

Do you use any of the following:

	Tobacco		Alcohol		Coffee/Tea		Cola

Patient signature______________________________________ Date ____________________

Assignment of Benefits Form

Texas Spinal Care
9610 Westheimer Road
Houston, TX 77063
Phone: (713) 278-2225
Fax: (713) 917-0604

Patient: ______________________________ Date: ____________________

Employer: ____________________________

Claim#: ______________________________

SS#/ID#: _____________________________

I hereby instruct and direct ___________________________ Insurance Company to pay by check made out and mailed to:

Texas Spinal Care
9610 Westheimer Road
Houston, TX 77063

OR

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Texas Spinal Care
9610 Westheimer Road
Houston, TX 77063

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. ***This is a Direct Assignment of my Rights and Benefits under this Policy.*** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

____________________________________ ____________________

Signature of Policyholder Date

____________________________________ ____________________________________

Witness Signature of Claimant, if other than Policyholder

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that **I have read them** or **declined the opportunity to read them** and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for seven years.

____ __________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative (please print)

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR 7 YEARS.