NEW PATIENT INFORMATION SHEET

Date: _____

Patient Name: _____ Soc. Sec. #:_____-_____-_____

Address: _____ Date of Birth: _____-____-_____

City: _____ State: _____ Zip: _____ Age:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

E-mail: _____

Children's Names & Ages: _____

_____

Insured's Name (If different than Spouse): _____

Emergency Contact Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ Phone #: (_____)_____-_____

Insurance Information (Note: Leave Blank if Personal Insurance Card is provided to be copied.)

Name of Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Adjustor: _____

Claim Number: _____

Phone #: (_____)_____-_____ Fax: (_____)_____-_____

Attorney Information (Note: Fill out information below in case of Auto Accident)

Attorney +/or Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Adjustor: _____

Phone #: (_____)_____-_____ Fax: (_____)_____-_____

Contact Name: _____

SUBJECTIVE COMPLAINT

Patient's Name _____ Date: _____/____/_____

DESCRIBE WHAT RECENTLY CAUSED &/or AGGRAVATED YOUR CONDITION? (Must be completed.)

❑ **Unknown**

(Give: If an auto accident give details including: Traveling/speed or stopped/foot on brake, where car was & how much damaged ($), what areas hit what in the car, car impacted the guardrail, car in front, etc...)

Auto Accident: Yes No Work Related Injury: Yes No Time: _____AM PM Date of injury: _____/_____/_____

If auto accident, Circle: Driver Passenger Where: Front Back - (Lt Center Rt)

Belted: Yes No Airbags Deployed: Yes No Were you aware the accident was going to occur? Yes No

Did you go to hospital? ❑ YES ❑ NO Which one: _____

If yes, how did you get there: ❑ By ambulance ❑ Driven by friend or family ❑ Drove self

WHERE PAIN IS	**HOW OFTEN**	**When**	**IS PAIN GETTING?**
Area #1: _____	Constant On & Off	_____	Better Same Worse
Area #2: _____	Constant On & Off	_____	Better Same Worse
Area #3: _____	Constant On & Off	_____	Better Same Worse
Area #4: _____	Constant On & Off	_____	Better Same Worse
Area #5: _____	Constant On & Off	_____	Better Same Worse
Area #6: _____	Constant On & Off	_____	Better Same Worse
Area #7: _____	Constant On & Off	_____	Better Same Worse

WHEN DID SYMPTOMS BEGIN RECENTLY?_____

DOES YOUR SYMPTOMS INTERFERE WITH YOUR: (Circle) Daily Routine School Sleep Work

Other _____

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM: (Circle) Bending of _____

Lying down Sitting Standing Turning of _____ Other _____

ACTIVITIES UNABLE TO DO SINCE IT BEGAN: _____

WHAT ARE YOUR MOST PHYSICALLY DEMANDING ACTIVITIES: (For example: Sports, yard work, etc.)

_____

Employer: _____ **Total Hours:** _____ **per week**

Job Title: _____ **Work days missed due to Accident:** _____

Patient's Signature: _____ Doctor's Signature: _____

Patient's 1st Language: _____ Translator's Initial: ____ Pamala A. Mitchell, D.C.

MEDICAL HISTORY

PAST MEDICAL HISTORY (DISEASES YOU HAVE BEEN DIAGNOSED AS HAVING BY A DOCTOR): ❑ NONE

- ❑ AIDS
- ❑ ALLERGIES
- ❑ ANEMIA
- ❑ ARTHRITIS OR GOUT
- ❑ ASTHMA
- ❑ BRONCHITIS OR PNEUMONIA
- ❑ CANCER (Where?) _____
- ❑ CORONARY ARTERY
- ❑ DIABETES
- ❑ EMPHYSEMA
- ❑ HEART ATTACK
- ❑ HIGH BLOOD PRESSURE
- ❑ HIGH CHOLESTEROL
- ❑ SEIZURE DISORDER
- ❑ STOMACH ULCERS
- ❑ STROKE
- ❑ THYROID DISEASE
- ❑ URINARY TRACT INFECTION
- ❑ OTHER DISEASES: _____

PAST SURGERIES (ANY OPERATIONS YOU HAVE HAD): Give Dates, please. ❑ NONE

- ❑ APPENDIX _____
- ❑ C-SECTION _____
- ❑ GALLBLADDER _____
- ❑ HYSTERECTOMY
  - ❑ PARTIAL _____
  - ❑ COMPLETE _____
- ❑ JOINT REPLACEMENT (Where?) _____
- ❑ HERNIA (Where?) _____
- ❑ TONSILS
- ❑ TUBIAL LIGATION
- ❑ CATARACTS
- ❑ CARDIAC BYPASS
- ❑ OTHER SURGERIES: _____

FAMILY HISTORY (WHAT ILLNESSES BELOW ARE PRESENT IN A BLOOD RELATIVE?): ❑ NONE

- ❑ ALLERGIES
- ❑ ANEMIA
- ❑ ARTHRITIS OR GOUT
- ❑ ASTHMA
- ❑ BRONCHITIS OR PNEUMONIA
- ❑ CANCER (Who? - Where ?) _____
- ❑ CORONARY ARTERY #____
- ❑ DIABETES #____
- ❑ EMPHYSEMA
- ❑ HEART ATTACK #____
- ❑ HEPATITIS OR CIRRHOSIS
- ❑ HIGH BLOOD PRESSURE #____
- ❑ HIGH CHOLESTEROL #____
- ❑ _____
- ❑ _____
- ❑ SEIZURE DISORDER
- ❑ STOMACH ULCERS
- ❑ STROKE #____
- ❑ THYROID DISEASE #____
- ❑ TUBERCULOSIS
- ❑ URINARY TRACT INFECTION
- ❑ OTHER DISEASES:_____

SOCIAL HISTORY:

- ❑ CIGARETTES
  - # OF PACKS PER DAY? _____
  - HOW MANY YEARS? _____
- ❑ CHEWING TOBACCO
- ❑ CIGARS
- ❑ NONE (Of the above.)

- ❑ ALCOHOL, WINE, OR BEER
  - # OF DRINKS PER DAY? _____
  - # OF DRINKS PER WEEK? _____
- ❑ RECREATIONAL DRUGS _____
- ❑ NONE (Of the above.)

DO YOU WEAR SEATBELTS?
YES / NO

BLOOD TRANSFUSION
YES / NO

List all prescription and non-prescription medication that you currently take: ❑ NONE _____

_____

List any medications that you are allergic to: ❑ NONE _____

For women only: Are you pregnant or might be at this time? Yes No

By signing below I acknowledge the above to be an accurate and truthful statement regarding my heath history.

Print Name: _____ Doctor's Signature: _____

Pamala A. Mitchell, D.C.

Patient's Signature: _____

Date: _____

Medical Record Release

I, _____, hereby request the release and transfer of:

❒ All Medical Records ❒ MRI Film & Report ❒ MRI Report ❒ Radiographic Films & Report

❒ Radiographic Report ❒ Test Results ❒ Other: _____

From the files of:

❒ _____
_____
_____

❒ Accident & Sports Injury Clinic
9179 Grissom Road, Ste.131
San Antonio, Texas 78251

To:

❑ Accident & Sports Injury Clinic
9179 Grissom Road, Ste. 131
San Antonio, Texas 78251

❑ _____
_____
_____

Authorization

I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by Accident & Sports Injury Clinic, which houses records. Redisclosure of my medial records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____(date supplied by patient); (3) under the following condition(s):

_____
_____
_____

_____ _____
Patient Signature Date

_____
Witness' Signature

1st Request Date: ____ -_____-_____ Staff Initials: _____ 2nd Request Date: ____ -_____-_____ Staff Initials: _____

ASSIGNMENT OF PROCEEDS, LIEN, AGREEMENT, AND AUTHORIZATION

I hereby authorize and direct all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities ("payer"), which may elect or become obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, illnesses, for which medical treatment or medical services were rendered hereunder ("condition") to pay directly and exclusively in the name of Pamala A. Mitchell, D.C. such sums as may be owed to Pamala A. Mitchell, D.C. for charges incurred by me at Accident and Sports Injury Clinic relating to my condition ("charges"), with such payments to be made exclusively in the name of Pamala A. Mitchell, D.C. I further grant a contractual lien to Pamala A. Mitchell, D.C., in accordance with the definitions, rights, and remedies of Texas law. For the purposes of this medical assignment and contractual medical lien, "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeding or recovery obtained as result of commercial health or group insurance, medical payments

I authorize Pamala A. Mitchell, D.C. 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 and Lien. I further authorize and direct all payers to release to Pamala A. Mitchell, D.C. any and all information regarding any coverage or benefits which I may provide for reimbursement to Pamala A. Mitchell, D.C. for medical services provided to me including, but not limited to, the amount and type of insurance coverage, the amount paid out on the condition thus far, and the amount of any outstanding claims. I hereby authorize Pamala A. Mitchell, D.C. to file a copy of this assignment and contractual lien with all public records in accordance with Texas law so as to provide public notice of this assignment and lien. In the event I retain one or more attorneys to represent me for the recovery for injuries which were sustained as the basis of this condition for which I sought medical treatment, I direct each and every attorney to issue a letter of protection to protect Pamala A. Mitchell, D.C.'s outstanding medical charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of Pamala A. Mitchell, D.C. I understand that Pamala A. Mitchell, D.C. is relying on this provision as one basis for the treatment being rendered to me or my dependent.

I understand that I will become personally responsible should any payer fail to honor this assignment. I understand that my personal responsibility is in addition to the obligation of any other payer, to the extent of my outstanding medical balance, costs, and expenses and enumerated herein, including attorneys' fees. I further understand and acknowledge that Pamala A. Mitchell, D.C. has rendered good and valuable services and consideration for this assignment and contractual lien including forbearance of payment for services rendered, for a reasonable period of time. In the event that Pamala A. Mitchell, D.C. must take any action to collect an outstanding balance on my account, I acknowledge and agree to be liable to reimburse Pamala A. Mitchell, D.C. for all costs incurred, including collection costs, court

This Assignment and Contractual Lien constitutes the complete agreement between the parties and revokes any other written agreements or oral agreements between the parties. I acknowledge that I have read this Assignment, Lien, and Agreement and that I execute this document freely, knowingly, and that I have had the opportunity to have this document reviewed by an attorney of my choice, and to rely upon their advice prior to signing this Assignment, Lien, Agreement, and Authorization affects

Patient Name (Please Print) _____ Patient Signature _____

Name of Custodial Parent or Legal Guardian (Please Print) _____

Date: _____