United Integrated Healthcare Center

NEW PATIENT INTRODUCTION

☐ Worker's Comp ☐ Private Pay
☐ Group Ins. ☐ Medicare
☐ Other _____

Patient: ☐ Mr. ☐ Mrs. ☐ Miss _____ Date _____
(First) (Middle) (Maiden) (Last)

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Co-habit Birth Date: _____

Home address _____ Home Phone: _____
(Street) (City) (Zip)

Referred by: _____
(Full Name) (Address)

Referral source: ☐ Spouse ☐ Co-worker ☐ Insurance company ☐ Family Email: _____

☐ Attorney ☐ M.D. ☐ Advertising Other _____

Patient employed by _____ Occupation: _____

Dept. _____ Employee No. _____

Business address _____ Business Phone: _____

Name of spouse _____
(First) (Middle) (Maiden) (Last)

Spouse/Co-habitor employed by _____

Dept. _____ Employee No. _____

Nearest relative not living with you _____ Relationship _____
(Name) (Address) (Phone)

Name of person legally responsible.
(if patient is a minor, name of parent, guardian, etc.) _____

INSURANCE

Do you have Medicare? ☐ Yes ☐ No # _____

1st Insurance company _____ Address _____

2nd Insurance company _____ Address _____

Group No./Membership No. _____

Are you insured? ☐ Yes ☐ No Or dependent? ☐ Yes ☐ No

NOTE: The following credit information is necessary when requesting insurance, monthly or weekly billing.

Bank _____ Branch _____ Account No. _____

Social Security No. _____ Driver's License No. _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorneys fees, and/or court costs will be added to the total amount due.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including MediCare, private insurance, and other health plans, to: _____

This assignment will remain in effect until revoked by the doctor in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED _____ DATE _____

RESPONSIBLE PARTY _____ DATE _____

(over)

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SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Stiff neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Grating sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

LOW BACK:
- ☐ Low back pain
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ Pinched nerve in low back
- ☐ Slipped disc
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

MID-BACK:
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain in mid-back
- ☐ Muscle spasms

ABDOMEN:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea

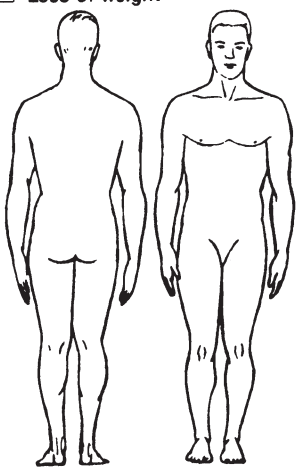
SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Pinched nerve in arm
- ☐ Pinched nerve in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs

HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)
- ☐ Pain down leg (R-L)
- ☐ Pain down both legs
- ☐ Leg cramps
- ☐ Pins & needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Cramps in feet (R-L)
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)
- ☐ Painful joints in toes
- ☐ Pain in foot (R-L)
- ☐ Pain in knee (R-L)

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Loss of sleep
- ☐ Loss of weight



MARK AREAS OF PAIN ABOVE

Have you had X-rays before? ☐ Yes ☐ No When? _____

What areas were X-rayed? _____

WOMEN ONLY: Date of last period? _____

☐ Menstrual pain ☐ Cramping ☐ Irregularity

Are you now pregnant? ☐ Yes ☐ No How long? _____

Purpose of this appointment: _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If So: Name _____ Date _____

Date of accident/illness _____ Hour _____ AM _____ PM Location: _____

How did accident occur? ☐ Auto Collision ☐ On-the-Job ☐ Other _____

Please describe the circumstances _____

_____

_____

Have you lost time from work? ☐ Yes ☐ No

Prior surgery _____

Medications taken presently _____

Previous accidents (other than described above) _____

_____

Parents living? ☐ Yes ☐ No In good health? ☐ Yes ☐ No