



“You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you live the quality of life you deserve.”

Date: _____ Chart#: _____

Name: _____ Sex: Male Female

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home #: (____) _____ Cell #: (____) _____ Other: (____) _____

DOB: _____ Age: _____ S.S. No. _____

E-mail: _____

Marital Status: Single Married Widowed Divorced

Referred By: Patient _____ Attorney _____

Physician _____ Mail Friend Other _____

Employer: _____ Business # (____) _____ Occupation: _____

Spouse's Name: _____ Contact #: (____) _____

Emergency Contact: _____ Phone #: (____) _____ Relationship: _____

Insurance Information

Insurance Co. Name: _____ Phone #: (____) _____

Insurance Type: Medical Auto Workers Compensation Other _____

ID/Policy #: _____ Group #: _____ Claim#: _____

Named of Insured: _____ DOB: _____ S.S. No _____

(If different from patient)

Is condition due to an accident? Yes No Date of Accident: _____ Time: _____ a.m. p.m.

If yes, please check one: Auto Work Other _____

Auto Accident Information

Were you the: Driver Front Passenger Rear Passenger

Location of Accident: _____ State _____

Year, Make & Model of the vehicle you were occupying? _____

Name of Owner: _____ Relationship to Patient: _____

Year, Make & Model of other vehicle(s) involved in accident? _____

Briefly describe accident: _____

Have you reported your accident to your auto insurance company? Yes No

Have you retained the services of an attorney? Yes No

If yes, Attorney's Name & Phone #: _____

Reason for Visit: _____

When did symptoms appear? _____ Is your condition getting progressively worse? Yes No

Does it interfere with your Work Family Life Sleep Recreation Exercise

Previous Chiropractic Care: No Yes If yes, approximate date of last visit _____

Please Check Area(s) of Pain:

- () HEAD () SHOULDER R/L () RIBS R/L () HIP R/L
- () FACE () UPPER ARM R/L () CHEST () THIGH R/L
- () JAW () ELBOW R/L () ABDOMEN () KNEE R/L
- () NECK () FOREARM R/L () MIDBACK () LOWER LEG R/L
- () WRIST R/L () LOWER BACK () CALF R/L () ANKLE R/L
- () HAND R/L () GROIN R/L () BUTTOCKS () FOOT R/L
- () FINGER R/L

Please Check Other Symptoms:

- () FATIGUE () NERVOUSNESS () TINGLING EXTREMITIES
- () ALLERGIES () NUMBNESS () CONSTIPATION
- () SLEEP LOSS () PARALYSIS () DIARRHEA
- () FEVER () DIZZINESS () SHORTNESS OF BREATH
- () HEADACHE () DEPRESSION () BLOOD PRESSURE
- () LOSS OF BALANCE () FAINTING () HEART PROBLEMS
- () LOSS OF SMELL () COLD EXTREMITIES () STROKE
- () LOSS OF TASTE () STRESS () TENSION/IRRITABILITY

Life Style:

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Computers Standing Light Labor Heavy Labor

Habits: Smoking Alcohol Coffee/Caffeine Drinks High Stress Level
Packs/Day _____ Drinks/Week _____ Cups/Day _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that I will provide the Doctor's Office with the necessary forms and/or reports to assist said Office in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to the insurance company and that I am responsible for any charges not paid by my insurance company and that I am ultimately responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor(s) to treat my condition, as he or she deems appropriate throughout my spine. The x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor(s) will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

As a result of my chiropractic care I would like to:

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Patient's Signature: _____

Date: _____

Guardian/Signature of Authorization: _____

Date: _____

HIPPA HAPPENINGS

Patient Authorization regarding chiropractic care being provided in an “open adjusting” environment.

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” involves several patients being seen at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related to an “open adjusting” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Rodolfo D. Alfonso.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

SUNSET CHIROPRACTIC & WELLNESS

I, _____, have received a copy of Sunset Chiropractic & Wellness' Notice of Patient Privacy Practices.

Signature of Patient

Date

**FORMULARIO PARA LA CONFIRMACION POR ESCRITO DE HABER
RECIBIDO AVISO DE LAS PRACTICAS DE PRIVACIDAD.**

Yo, _____, he recibido una copia del Aviso de las Practicas de Privacidad de Sunset Chiropractic & Wellness.

Firma del Paciente

Fecha

AUTHORIZATION TO PAY

I, _____ hereby authorize
(NAME OF INSURED)
_____ to pay directly to
(NAME OF INSURANCE COMPANY)
_____ the medical and/or
(NAME OF PHYSICIAN)
chiropractic benefits, if any, otherwise payable to me for his /her services, but not to exceed the charges for those services. I understand that I am financially responsible for those charges not paid by my insurance.

Signed: _____ Date: _____

**AUTHORIZATION FOR X-RAYS
(FEMALES ONLY)**

In order to protect you, the patient, we need to be assured that there is no possibility of pregnancy, should the doctor choose to order x-rays.

Please check the statement below that applies to you.

_____ There IS possibility that I am pregnant.

_____ There is NO possibility that I am pregnant.

Signed: _____ Date: _____

CONSENT TO EXAMINATION AND/OR TREATMENT

I hereby consent to be examined by Dr. _____ and receive treatment prescribed for my condition according to his findings and diagnosis. I further consent to continue treatment, if necessary, with a doctor designated by Dr. _____ to cover him/her in his/her absence.

Signed: _____ Date: _____
(IF PATIENT IS A MINOR, THIS FORM MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN)