Welcome to our practice!

Patient Information

Thank you for choosing Anaya Chiropractic & Sports Injury for your health needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: _____ Social security number: _____

Address: _____ City: _____ State: _____ Zip code: _____

Sex: ❑ Female ❑ Male Date of birth: _____ E-mail: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

Do you prefer to receive appointment reminders via: ❑ E-mail ❑ Home phone ❑ Work phone ❑ Cell phone

❑ Married ❑ Widow(er) ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient employer/school: _____ Occupation: _____

Employer/school address: _____ City: _____ State: _____ Zip code: _____

Spouse or parent's name: _____ Employer: _____ Work phone: (_____)_____

Who may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

Responsible Party

Name of person responsible for this account: _____ Social security number: _____

Relationship to patient: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip code: _____

Name of employer: _____ Phone: (_____)_____

Insurance Information

Insurance company name: _____ Phone: (_____)_____

Name of insured person (if other than patient): _____

Relationship of insured to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance policy number: _____ Insurance group number: _____

Insurance policy: ❑ Health ❑ Medicare ❑ Automobile ❑ Worker's compensation

Claim number if accident or injury: _____ Date of accident or injury: _____

Name of insurance case worker (if accident/injury): _____ Phone: (_____)_____

Accident/injury is related to: ❑ Employment ❑ Automobile ❑ Other _____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Light ❑ Moderate ❑ Heavy Type: _____

What do your daily work habits include? _____

What vitamins/nutritional supplements do you currently take? _____

_____

Do you smoke? ❑ Never ❑ Former smoker ❑ Occasional smoker ❑ Current smoker How much per day? _____

Do you drink alcoholic beverages? ❑ No ❑ Beer ❑ Wine ❑ Liquor How much per week? _____

How many caffeinated beverages do you consume daily? _____ Type: _____

How would you rate your overall health? ❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

*Symptoms*_____

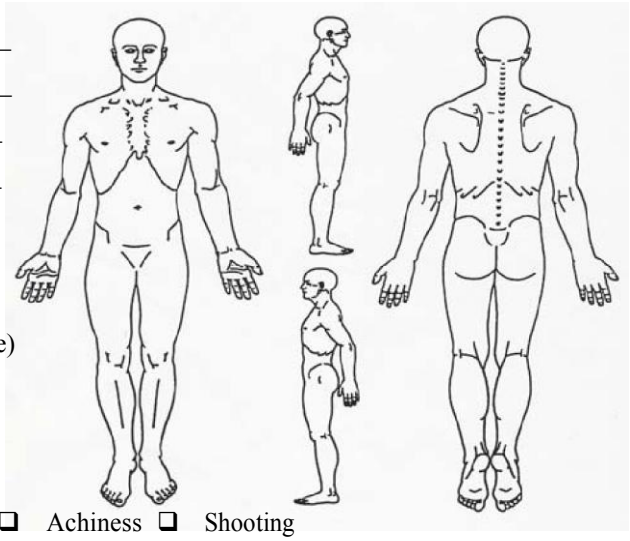
Reason for visit: _____

When did you first notice your symptoms? _____

How do you think your symptoms began? _____

_____

Indicate on the drawings to the right where you have pain/symptoms:



How often do you experience your symptoms?

❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Infrequently (1-25% of the time)

How are your symptoms changing with time?

❑ Getting worse ❑ Staying the same ❑ Getting better

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Achiness ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other: _____

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What aggravates your condition? _____

What makes your condition better? _____

What treatment have you received for your condition?

❑ Medication ❑ Surgery ❑ Chiropractic ❑ Physical therapy ❑ Massage ❑ None ❑ Other _____

How much has your condition interfered with your work and social activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

Do you consider your condition to be severe? ❑ Yes ❑ Yes, at times ❑ No

What concerns you the most about your condition? What does it prevent you from doing? _____

Health History *Check only those conditions which are applicable:* _____

❑ Headaches
❑ Neck pain
❑ Upper back pain
❑ Mid back pain
❑ Low back pain
❑ Shoulder pain
❑ Elbow/arm pain
❑ Wrist pain
❑ Hand pain
❑ Hip pain
❑ Upper leg pain
❑ Knee pain
❑ Ankle/foot pain
❑ Jaw pain
❑ Joint pain/stiffness
❑ AIDS/HIV
❑ Alcoholism
❑ Allergy shots
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Blood disorder
❑ Breast lump
❑ Bronchitis
❑ Bulemia
❑ Cancer
❑ Cataracts
❑ Chemical dependency
❑ Chicken pox
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fractures
❑ Glaucoma
❑ Goiter
❑ Gonorrhea
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ Hernia
❑ Herniated disc
❑ Herpes
❑ High cholesterol
❑ Kidney disease
❑ Liver disease
❑ Measles
❑ Migraines
❑ Miscarriage
❑ Mononucleosis
❑ Multiple sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's disease
❑ Pinched nerve
❑ Pneumonia
❑ Polio
❑ Prostate problems
❑ Psychiatric care
❑ Prosthesis
❑ Rheumatoid arthritis
❑ Scarlet fever
❑ Stroke
❑ Thyroid problem
❑ Tonsillitis
❑ Tuberculosis
❑ Tumor/growth
❑ Typhoid fever
❑ Ulcers
❑ Whooping cough
❑ Other: _____
_____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

List any surgeries/hospitalizations you have had and dates which they occurred: _____

_____

List any traumas/motor vehicle accidents/fractures you have had and dates which they occurred: _____

_____

Health History, continued _____

Please list all medications you are currently taking: _____

_____

Allergies: _____

*Family History*_____

Indicate if you have any family members with a history of the following:

❑ Rheumatoid arthritis ❑ Diabetes ❑ Lupus ❑ ALS ❑ Thyroid condition
❑ Heart Problems ❑ Cancer ❑ Stroke ❑ Seizures ❑ Other: _____

Motor Vehicle Accident *(if applicable)* _____

Date of accident: _____ Time of accident: _____

How and where did the accident happen? _____

Where were you sitting at the time of the accident? _____

Please mark the following that apply at the time of the accident:

❑ Wearing seat belt ❑ Air bag deployed ❑ Body hit interior of car ❑ Ejected from vehicle ❑ Lost consciousness

❑ Unaware of impending collision ❑ Aware of impending collision and relaxed ❑ Aware of impending collision and tightened up

What happened after the accident?

❑ Police arrived ❑ Ambulance arrived ❑ Taken by ambulance to hospital ❑ Police report written
❑ Refused treatment ❑ Drove to hospital ❑ Went to doctor's office ❑ Other: _____

Immediately after the accident, where did you feel pain/symptoms? _____

Currently where do you feel pain/symptoms? _____

Other treatment received for this accident: _____

Worker's Compensation Injury *(if applicable)* _____

Date of injury: _____ Time of injury: _____

How and where did the injury happen? _____

What happened after the injury?

❑ Continued working ❑ Stopped working ❑ Notified supervisor ❑ Incident report written
❑ Drove to hospital ❑ Went to doctor's office ❑ Received no treatment ❑ Other: _____

Immediately after the injury, where did you feel pain/symptoms? _____

Currently where do you feel pain/symptoms? _____

Are you currently working? ❑ Yes, without restrictions ❑ Yes, with restrictions ❑ No

Other treatment received for this injury: _____

*Patient Payment Agreement*_____

Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the doctor. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to my health record.

Signature _____ Date _____

Anaya Chiropractic & Sports Injury Center

338 E Betteravia Rd., Suite D

Santa Maria, CA 93454

Ph 805-925-9299 Fax 805-349-0072

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICE

PATIENT NAME:_____

I understand that under the "Health Insurance Portability & Accountability Act of 1996" (HIPAA), that I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and/or indirectly;

2) Obtain payment from third party payers;

3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been informed and had access to Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Anaya Chiropractic has the right to change their Notice of Privacy Practices from time to time and that I may contact them at any time to obtain a copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient signature _____

Date: _____

FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE:

Many insurance policies do cover chiropractic treatment, but this office makes no representation that yours does. Insurance policies may differ greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you the patient, be personally responsible for the payment of deductibles as well as any unpaid balances in the office. We will do our best to verify your insurance coverage and will bill your insurance in a timely manner as a courtesy to you.

PAYMENT ARRANGEMENTS:

If you have insurance, we will bill for you as a courtesy. Payment for deductibles is the responsibility of the patient as well as any copayment or remaining balance after the insurance payment. Your co-pay/coinsurance is due as services are rendered. You are also responsible for portions of your bill that exceed your insurance limits.

ASSIGNMENT OF BENEFITS:

By signing this form, you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

RELEASE OF INFORMATION:

If your insurance company requires medical reports to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

We hope this answers any questions you might have concerning the financial policy of this office. Once again, we welcome you to our office, and will be glad to answer any further questions you may have.

I HAVE READ AND AGREE TO THE ABOVE.

_____ _____

Signature **Date**

ANAYA CHIROPRACTIC & SPORTS INJURY CENTER

338 E. BETTERAVIA RD. SUITE D

SANTA MARIA, CA 93454

PH: 805-925-9299 FAX: 805-349-0072

Cancellation/No show Fee

We understand that you may sometimes need to reschedule appointments. When we make you an appointment please understand we are reserving time for you to see the doctor. This courtesy makes it possible to give the best service here at Anaya Chiropractic. If you need to reschedule an appointment, please call as soon as possible to notify us of a cancellation.

If you have a no-show for your appointment more than one time you will be charged a $25 no-show fee.

_____ _____

Signature

Date