

AMERICAN HEALTH LASERS New Patient Form

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PATIENT INFORMATION

Date _____
 SS/HIC/Patient ID# _____
 Patient Name: _____

 Address _____
 City _____
 State _____ Zip _____
 Email _____
 Sex M F Age _____
 Birth date _____
 Married Single Widowed Minor
 Separated Divorced Partnered for _____ years.
 Patient Employer/School _____
 Occupation _____
 Employer/School Address _____
 Employer/School Phone (____) _____
 Spouse's Name _____
 Birthdate _____
 Spouse's Employer _____
 Whom may we thank for referring you?

 Check here if you do not wish to receive correspondence by email from ISPI

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AUTHORIZATION FOR CARE, FINANCIAL ARRANGEMENT & PRIVACY POLICY

Consent to treat and Financial Agreement

I do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, order diagnostic X-rays, order laboratory tests, and any treatment that in their judgment deemed advisable or is required, but not limited to adjustments to the spine and extremities, as well as any physiotherapy required for my condition, including but not limited to muscle work, electrical modalities and exercise. I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, strokes, disk injuries, dislocations and sprains and strains. I do not expect the doctor to be able to explain and anticipate all risks and complications. I wish to relay to the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then best known, is in my best interest. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all bills incurred at this office. I understand that all payments are due on the day when services are rendered. The Doctor will be aware but will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Cancellation Policy

I also understand that the doctor's time is extremely valuable, and the numbers are available patient slots for a given day is limited and thus a 24 hour cancellation policy is strictly enforced. By signing below I agree to abide by the 24 hour cancellation policy which states that - Notice of at least 24 hours is required for cancellation. Should you cancel later than 24 hours before your intended appointment, we reserve the right to retain 50% of the normal fee due. If you fail to cancel altogether, you will be responsible for the entire fee.

Consent to Treat a Minor

I (we) being the parent (s), guardians(s) or custodian(s) of the minor _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for the payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Privacy Policy

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of ISI's "NOTICE OF PRIVACY PRACTICES," revision date: 01/11/11

As required by the privacy regulations, _____ from has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction. I have read the Privacy Policy Notice and understand my right contained in the notice.

By way of my signature, I provide ISI with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

X

Sign and print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

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PHONE NUMBERS

Cell Phone (____) _____ Home Phone (____) _____
 Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
 Name _____ Relationship _____
 Home Phone (____) _____ Work Phone (____) _____

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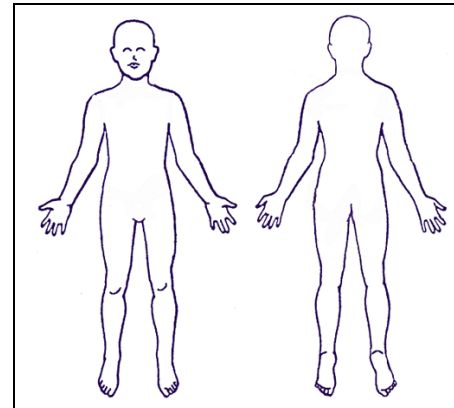
ACCIDENT INFORMATION

Is condition do to an accident? Yes No Date _____
 Type of Accident Auto Work Home Other
 To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other
 Attorney name (if applicable) _____

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PATIENT CONDITION

Reason for Visit _____
 When did your symptoms appear? _____
 Is this condition getting progressively worse? Yes No Unknown
 Mark an X on the picture where you continue to have pain, numbness, or tingling.
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
 Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other
 How often do you have this pain? _____
 Is it constant or does it come and go? _____
 Does it interfere with your Work Sleep Daily Routine Recreation
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



What Treatments have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and addresses of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

EXERCISE <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	WORK ACTIVITY <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	HABITS <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Date of last Menstrual cycle: _____ (circle) Regular/Irregular Date of last OB/GYN exam: _____ (circle) Normal/Abnormal
 Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____

MEDICATIONS		ALLERGIES	VITAMINS/HERBS/MINERALS
MEDICATION TYPE/NAME	FOR WHAT CONDITION		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____