Chiropractic Consultants
OF HOUSTON

Established in 1992

NEW PATIENT FORM

DR. DINO PALIVIDAS
ASHFORD PROFESSIONAL BUILDING
909 Dairy Ashford, Suite 103
Houston, Texas 77079
(281) 589-2424
(281) 589-2476 Fax

Date_____ Referred by _____

Name_____ Date of Birth_____

Address_____

City/St/Zip_____

Home Phone(____)_____ Cell Phone (____)_____

WHAT NUMBER DO YOU PREFER TO BE CONTACTED AT? H C WK

Employer_____ Work Phone(____)_____

Position Held_____ E-MAIL_____

Marital Status_____ No. Children_____ Sex_____ Weight _____

Height_____ Age_____ SS#_____

In case of emergency, contact_____ Phone#_____

Name of Person Responsible for this account_____

Name of Insurance Co._____ Phone#_____

Policy#_____ Group#_____

POLICY IS UNDER WHAT NAME_____ H/HER DOB_____

YOUR MAIN PROBLEM

What problem would you most like treated?_____

Is this problem with you _____Constantly _____Frequently _____Other

What brought this problem on?_____

How long have you had this problem?_____

When is the problem worst?_____

How does this affect your lifestyle/work?_____

Was this problem caused by an accident?_____ If yes, what kind?_____

Have you seen another doctor for this problem?_____

If yes, name of doctor_____

Please give the name of your M.D._____ Phone #_____

How do you want us to handle your problem?
_____Temporary Relief (Help the symptom but do not fix the cause of the problem)
_____Maximum Correction (Correct the cause of the problem for maximum stability in the future)
On a scale of 1 to 10 (10 being the most, and 1 being the least)
_____How Committed are you at being at your maximum potential?
_____How important is it for your family to be at their maximum health potential?
_____How committed are you to preventing arthritis and maximizing your spinal stability?

A. The vast majority of our patients have experienced literally dozens of impacts that could cause vertebral subluxations (Spinal condition resulting in an interference and irritation of the nerve).

1. How many auto accidents (even fender benders) have you been in? (Please Circle)
   0 1-2 3-4 5+ Motorcycle Accidents? _____
2. Which of the following sports have you been involved in: (Please Circle)
   Football Basketball Baseball Soccer Hockey Gymnastics Martial Arts
   Dance Wrestling Horseback Riding Skating Water Sports Other _____
3. Have you ever…(Please Check)
   ( ) Fallen down the stairs ( ) Had a strain/sprain injury
   ( ) Slipped and fell ( ) Had a sports injury
4. Do you…(Please Check)
   ( ) Sit more than four hours per day ( ) Drive more than two hours per day
   ( ) Work at a computer more than two hours per day
5. What type of work do you do? _____

B. Subluxations can cause malfunctions in any part of the body. Please check all the health complaints you are currently experiencing.

( ) Neck pain	( ) Arm/Hand problem	( ) Ear infections	( ) Dizzy/Light headed
( ) Upper/Mid back pain	( ) Leg/Foot problem	( ) Frequent colds	( ) Fatigue
( ) Low back pain	( ) Asthma	( ) Digestive problems	( ) Depression
( ) Headaches	( ) Allergies	( ) High blood pressure	( ) Numbness
( ) Spinal curvature	( ) Sinus problems	( ) Diabetes	( ) Tingling

( ) Other _____

C. Subluxations can put pressure on nerves for long periods of time.
How long have you had the above complaints? _____

D. Nerve pressure and irritation can be constant or occasional.
How often do you have the above complaints? _____

E. Irritations to different nerve fibers can create different sensations.
Is yours: ( ) Sharp ( ) Dull ( ) Throbbing ( ) Achy ( ) Burning ( ) Tingling ( ) Numbness

F. Subluxations can cause a weakening of the entire spine.
Is yours worse: ( ) In the morning ( ) Late in the day ( ) At night ( ) All the time ( ) After activity

Major Surgeries _____
Major Falls/Accidents _____
List all drugs that you currently take _____
Who is financially responsible for this bill? _____

I AUTHORIZE THE DOCTORS AND STAFF OF THIS CLINIC TO EXAMINE AND TREAT ME AS THEY FIND NECESSARY.

Patients Signature _____ Date _____

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Chiropractic Consultants of Houston or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to to this office to use and disclose my health information in accordance with it.

_____

Name of Patient (Print)

_____

Signature of Patient **Date**

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

_____

Office Representative **Date**

Chiropractic Consultants
OF HOUSTON

Established in 1992

DR. DINO PALIVIDAS
ASHFORD PROFESSIONAL BUILDING
909 Dairy Ashford, Suite 103
Houston, Texas 77079
(281) 589-2424

AUTHORIZATION FOR EXAMS, X-RAYS, AND TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. C.S. Palividas to perform any necessary examinations, take any clinically necessary x-rays, and perform any treatments or procedures that are therapeutically necessary.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due.) I personally owe you. I have read all the information on this patient form. I recognize that there is no guarantee of results. I verify the information is true and correct to the best of my knowledge.

Signature_____DATE _____
(If the patient is a minor, signature of parent, guardian, etc.)