Who can we thank for referring you to our clinic? A quien podemos agradecer por remitirlo a nuestra clinica?

_____

Name/Nombre_____D.O.B/Fecha De Nacimiento_____Sex/Sexo[M F] Age/Edad_____

Address/Dirección_____

City/Cuidad_____State/Estado_____Zip Code/Código Postal_____

Home Phone/Telef. De Casa_____Cell Phone/Telef. Celular_____Work Phone/Telef. Trabajo_____

Social Security/Seguro Social_____Number of children & ages/Numero De Hijos & Edades_____

E-mail/Correo Electrónico_____Can We Sent Text Messages?/Nos Permite mandarle mensajes?_____

Employer/Empleador_____Position/Posición_____

Marital Status-circle one [M S D W] Estado Civil-*circulo* [S C V D] Are you Pregnant? [Y N] Estas Embarazada? [S N]

Are you insured? [Y N] Tienes Seguro Medico? [S N] Insurance Company/Seguro Medico_____

Spouse Name/Nombre de Esposa/o_____Employer/Empleado_____

PCP Doctor/Doctor Primario_____PCP Doctor Phone/Telef. De Doctor Primario_____

IS TODAY'S PROBLEM CAUSED BY/EL PROBLEMA FUE CAUSADO POR-*circle one/circulo:*

[AUTO ACCIDENT/ACCIDENTE DE CARRO- WORK INJURY/LESION DE TRABAJO-OTHER/OTRO] _____

WHAT IS YOUR HEIGHT? / CUAL ES SU?: HEIGHT/ESTATURA_____WEIGHT/PESO_____

INDICATE IF YOU HAVE ANY IMMEDIATE FAMILY MEMBERS WITH ANY OF THE FOLLOWING/INDIQUE SI ALGUN FAMILIAR CERCANO TIENE ALGUNA DE LAS SIGIENTES CONDICIONES:

[ ] RHEUMATOID ARTHRITIS/ARTRITIS REUMATOIDE [ ] DIABETES/DIABETES [ ] LUPUS/LUPUS
[ ] HEART PROBLEMS/PROBLEMAS DE CORAZON [ ] CANCER/CANCER [ ] ALS/ELA

FOR EACH OF THE CONDITIONS LISTED BELOW, PLACE A CHECK IN THE "PAST" COLUMN IF YOU HAVE HAD THE CONDITION IN THE PAST. IF YOU PRESENTLY HAVE A CONDITION BELOW, PLACE A CHECK IN THE "PRESENT" COLUMN.
PARA CADA UNA DE LAS CONDICIONES LISTADAS ABAJO, POR FAVOR MARQUE "PASADO" SI HA TENIDO LA CONDICION EN EL PASADO. SI TIENE ALGUNA DE ESTAS CONDICIONES EN EL PRESENTE POR FAVOR MARQUE "PRESENTE".

PAST PASADO	PRESENT PRESENTE	
[ ]	[ ]	High Blood Pressure/ Presión Alta
[ ]	[ ]	Diabetes/ Diabetes
[ ]	[ ]	Heart Attack/ Ataque De Corazón
[ ]	[ ]	Excessive Thirst / Sed Excesiva
[ ]	[ ]	Chest Pains/ Dolor de Pecho
[ ]	[ ]	Stroke/ Derrame Cerebral
[ ]	[ ]	General Fatigue/ Fatiga
[ ]	[ ]	Angina/ Palpitaciones
[ ]	[ ]	Kidney Stones/ Piedras En Los Riñones
[ ]	[ ]	Arthritis/ Artritis
[ ]	[ ]	Kidney Disorders/ Problemas Riñon
[ ]	[ ]	Depression/ Depresión
[ ]	[ ]	Allergies/ Alergias
[ ]	[ ]	Dizziness/ Mareo
[ ]	[ ]	HIV/AIDS/ HIV/SIDA
[ ]	[ ]	Cancer/ Cancer
[ ]	[ ]	Painful Urination/ Dolor al Urinar
[ ]	[ ]	Tumor/ Tumor
[ ]	[ ]	Loss of Bladder Control/ Incontinencia urinaria ó al orinar
[ ]	[ ]	Asthma/ Asma
[ ]	[ ]	Prostate Problems/ Problemas De Prostate
[ ]	[ ]	Chronic Sinusitis/ Sinusitis Crónica

PAST PASADO	PRESENT PRESENTE	
[ ]	[ ]	Systemic Lupus/ Lupus
[ ]	[ ]	Abdominal Pain/ Dolor Abdominal
[ ]	[ ]	Epilepsy/ Epilepsia
[ ]	[ ]	Ulcer/ Ulcera
[ ]	[ ]	Hepatitis/ Hepatitis
[ ]	[ ]	Bladder Infection/ Infección De Vajiga
[ ]	[ ]	Frequent Urination/ Orina Frequente
[ ]	[ ]	Liver/ Gall Bladder Disorder/ Higado/ Vesicula Inflamada
[ ]	[ ]	Smoking/Tobacco Use Amount/ Fumar/Masca Tobaco Cuanto?_____
[ ]	[ ]	Alcohol Use Amount/ Bebidas Alcohólicas Cuanto?____
[ ]	[ ]	Muscular Incoordination/ Muscular Descoordinación
[ ]	[ ]	Visual Disturbances/ Problemas Visuales
[ ]	[ ]	Joint Pain/Stiffness/ Dolor conyonturas
[ ]	[ ]	Rheumatoid Arthritis/ Artritis Reumatoide
[ ]	[ ]	Dermatitis/Eczema/Rash/ Dermatitis/Eczema/Erupción
[ ]	[ ]	Abnormal Wight Gain/Less/ Perdida De Peso anormal/ Aumento de Peso Anormal
FOR FEMALES ONLY		
[ ]	[ ]	Birth Control Pills/ Pastillas Anticonceptivas
[ ]	[ ]	Hormonal Replacement/ Terapia De Reemplazo Hormonal
[ ]	[ ]	Pregnancy/ Last menstrual period? Embarazo/ Ultimo

[ ] [ ] Loss of Appetite/ Perdida De Apetito Ciclo Menstrual_____?

ALLERGIC TO ANYTHING? [Y N] IF SO, WHAT? / TIENES ALGUN ALERGIA? [Y N] CUALES SON? _____

LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING/ LISTE TODOS LOS MEDICAMENTOS RECETADOS QUE ESTA TOMANDO ACTUALMENTE:

_____

_____

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD/ ANOTE TODOS LOS PRECEDIMIENTOS CIRUJIAS QUE HA TENIDO:

_____

HAVE YOU EVER BEEN HOSPITILIZED? [ ] NO [ ] YES ¿HAS SIDO HOSPITALIZADO ALUNA VEZ? [ ]SI [ ]NO

IF YES, WHY? / QUE FUE LA RAZON? _____

I understand and agree that medical insurance policies are an arrangement between my insurance company and myself- not my insurance company and this office. I authorize this office to release any medical information and complete any usual and customary reports and forms at no charge, to assist in collecting from my insurance company. However, I understand that I am ultimately responsible for payment in full and agree to pay a $10 per month billing charge and a 1.5% monthly interest charge for all unpaid balances, which become 30 days past due. If necessary, I also agree to take full responsibility for all third-party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I have read this financial policy. I understand and agree to all terms of this policy.

Entiendo y acepto que las pólizas de aseguranza medico son un acuerdo entre mi compañia de seguros y yo, no mi compañia de seguros y esta oficina. Autorizo a esta oficina para devulgar cualquier información medica y completer los informes y formularios habituales sin cargo, para ayudar a cobrar a mi compañia de seguros. Sin embargo, entiendo que soy responsible en ultima instancia del pago total y acepto pagar un cargo de facturación mensual de $10 y un cargo de interes mensual del 1.5% por todos los saldos pendientes de pago, que se vencen en 30dias. Si es necesario, tambien acepto asumir la responsabilidad total de todos los costos de terceros compañias involuerdas en mi caso, incuidas las agencias de cobro, los precios razonables de abogados y / o los costos judiciales incurridos al intentar cobrar esta deuda. Tambien entiendo que si suspendo o doy por terminada mi atención y tratamiento, cualquier dinero que yo deba han brindado por los servicios profesionales que se me brinden se pagara de inmediato. He leido esta politica financiera. Entiendo y acepto todos los terminos de esta politica.

SIGNATURE/ FIRMA_____DATE/FECHA_____

(Parent signature if minor)

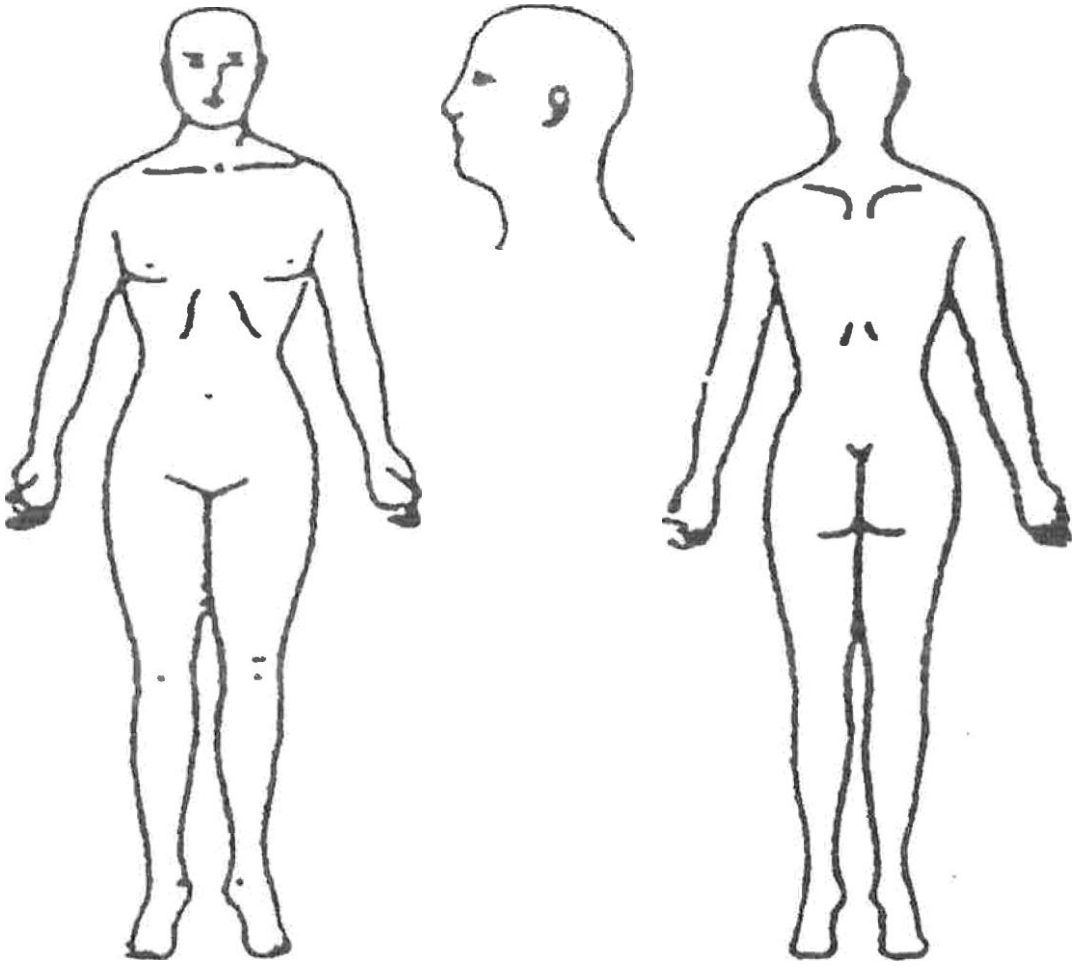
DOCTOR SIGNATURE_____DATE _____

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches /\/\/ *Numbness oooo* *Pins/Needles ● ● ● ●* *Burning xxxx* *Stabbing ////*



Reference Ranosford Spine. Vol 1. No 2, June 1976

FORM 504