Urteaga Chiropractic & Sports Medicine

General Info

Patient Name:_____Today's Date:_____
Home Address: _____
City:_____State:_____Zip Code_____
Primary Phone:( )_____
Email Address:_____
DOB:_____SSN#: _____

Emergency Contact:_____
Relationship to Patient: _____
Home Address: _____
Home Phone:_____Cell Phone: _____
Email:_____

Medical Information

Age: _____ Height: feet= ____ Inches=____ Weight:_____lbs
Recent medical procedures:_____Date:_____
ALL Prescribed Medications:_____
ALL Over-the-Counter Medications:_____
Known congenital (from birth) factors that relate to your condition?
❑ No ❑ Yes➤_____
Do you have a pacemaker?
❑ No ❑ Yes➤_____
Is there any chance you may be pregnant? ❑ No❑ Yes ➤ # of weeks_____

Case Information

If you have an attorney	If you DO NOT have an attorney
Law Office/Attorney:	Other Party's Insurance:
Point of Contact:	Claim Number:
Address:	Adjuster Name:
Phone Number:	Email:
Email:	❑ Check here of you do not have this information or plan to use your own car insurance
Other info:	

Urteaga Chiropractic Policies, Terms & Conditions

Initials®_____If I fail to attend my scheduled appointment without cancellation notice 24 hours prior, I agree to pay a $25 no show/late cancellation fee.

Initials®_____I am responsible & directly liable for payment of any outstanding balances. Any deductibles, co-payments, co-insurance or other fess for any office service rendered are payable at the time of my visit, unless other arrangements have been made & agreed upon prior to treatment.

Initials®_____I agree to notify the office promptly of any changes to my health insurance policy, or other pertinent information.

Initials®_____I have and will notify the office of any previous auto/work related injuries that I may suffer hereafter.

Initials®_____A $25 fee will be charged for all returned checks.

Authorization & Assignment

I give authorization to this office to contact my primary care physician and/or relevant health care providers & specialists regarding co-management of my health. I request & authorize direct payment of any medical or automotive insurance company benefits or any

Informed consent

I hereby request and consent to the consultation, examination, performance of chiropractic adjustments and related chiropractic procedures on patient named below for which I am legally responsible, by the doctor or intern directly supervised by doctor, as needed. Results are not guaranteed and there is no promise to cure any health condition. I understand that there are some risks to treatment, including but not limited to muscle soreness, spasms, sprains, strains, dislocations, disc injuries, fractures and strokes, most with extremely rare incidence. I do not expect the provider to be able to anticipate and explain all risks and complications. I wish to rely on the provider to exercise judgment during the course of the procedures which the provider feels at the time, based on the facts then known, is in my best interest. The provider will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I agree to inform staff of any pre-existing conditions, limitations, specific sensitivities or discomfort at any time. I have read the above consent and I understand that I can ask the doctor and staff at anytime regarding any risks or concerns. Any questions, comments, or complaints may be brought to the attention of staff. By signing below, I agree to the above, and allow the provider or supervised chiropractic intern affiliated with Urteaga Chiropractic to perform such as described above. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. Urteaga Chiropractic is not responsible for lost or stolen articles or items.

Privacy Confidentiality Statement

I am aware of this office has privacy notice and understand my rights. I understand that this privacy notice is also available at www.urteagachiropractic.com. By signing below, I provide this office with my authorization and consent to use in disclose my personal health information for the purpose of treatment, payment and healthcare operations as described in the notice.
I certify that all the information I have entered on all accompanying pages to this form is complete & accurate to the best of my knowledge. I have read and understand the above terms.

X_____X_____X_____

Signature of Patient/Parent | Patient/Parent Print Full Name | Date

Consent to treat minor

I am the parent/legal guardian of the patient who is of minor age. I hereby give my consent and authorize & request all procedures & treatments as stated above as deemed advisable on this minor patient.

Signature of Minor's Parent/Guardian:_____Date:_____