Integrated Chiropractic Healthcare, P.A.

Dr. José R. Cadavedo & Dr. Nayda M. Nuñez

213 S. Dillard St. Suite 230, Winter Garden, FL 34787
Tel: (407) 347-5953 Fax: (407) 614-5911 Email: info@ichcare.com

PATIENT REGISTRATION

Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Sex: Male / Female SSN: _____

Address: _____
Street *City* *State* *ZIP*

Home Phone: _____Cell Phone: _____Cellphone Carrier: _____ Work Phone: _____

Occupation: _____ Email Address: _____ Marital Status: S M D W

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Health Insurance Information ☐ **No Health Insurance Benefits**

Insured's Name: _____

Relationship: _____ Insured's Date of Birth: _____

Insurance Carrier: _____ Insurance Phone/Fax: _____

Address: _____
Street *City* *State* *ZIP*

Policy #:_____ Group #:_____

Assignment of Benefits – I authorize the release of any medical information necessary to process this claim and request payment of benefits from my insurance company be made to Integrated Chiropractic Healthcare. I understand and agree that regardless of my insurance status); I am ultimately responsible for the balance on this account. I have read and completed all the information on this sheet to the best of my ability and certify that it is true and correct. I will notify you of any changes on the above information. _____ **Initials**.

Informed Consent of Treatment – I understand that spinal manipulation has health risks associated, example: fractures, sprains/strains, cerebral vascular accident, cauda equine syndrome, nerve root irritation, and spinal cord compression _____ **Initials.**

Privacy Practices – I acknowledge that I was provided a copy of the NOTICE OF PRIVACY PRACTICES and that I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES. I understand that this form will be placed in my patient chart and maintained for six years. _____ **Initials.**

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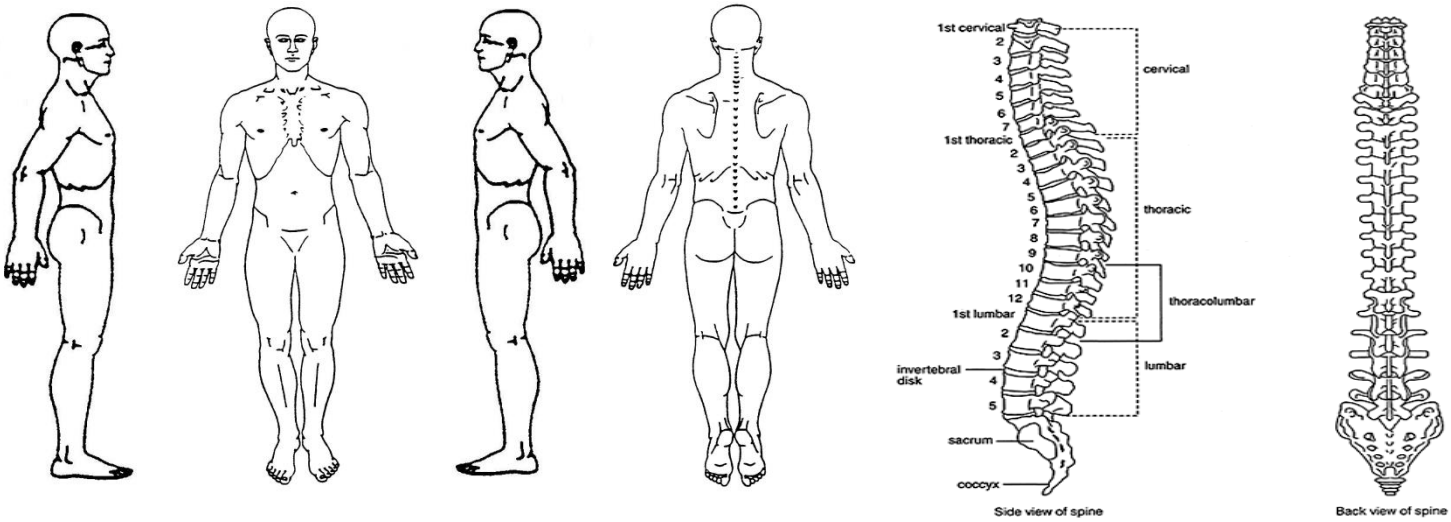
INITIAL PATIENT QUESTIONNAIRE

Name / Nombre:_____ Date / Fecha:_____

Reason for visit? / Rason por visita? _____

On pictures, mark an X where you feel pain or discomfort / En las fotos abajo, marca con una X donde siente dolor :



When did your symptoms first appear? / Cuando comenzaron los síntomas? _____

Is the condition getting progressively worst? / La condición se está empeorando? : YES NO

Visual Analog Scale

No pain / Nada de dolor — Excruciating Pain / Mucho Dolor

Indicate the type of pain / indica la clase de dolor : _____

Previous Treatments for this complaints / Tratamientos previos para esta condición:

_____

_____

Other complaints or problems / Otros problemas:

_____

_____

Current medications / Medicamentos:

_____

_____

Are you currently under the medical care of another doctor? / Esta usted bajo la atención medica de otro doctor? YES NO

If so, when was your last visit / De haber visitado al doctor, cuando fue su última visita:

_____

List any major illnesses, with approximate dates / Liste sus condiciones médicas, con fechas aprox.: _____

_____

Patient Name/ Nombre de Paciente:_____

List any major surgeries or operations with approximate dates / Anota tus cirugía o operaciones, con fechas:

_____

List any past accidents or injuries / Anotas algún accidente o herida:

_____

_____

Have you ever been diagnosed with the following? / Alguna vez te han diagnosticado con lo siguiente ?

○ Diabetes ○ Heart Disease ○ High Blood Pressure ○ Cancer ○ Asthma	○ Allergy ○ Tuberculosis ○ Herpes ○ STD ○ HIV/AID	○ Depression ○ Metal Disorder ○ Liver Problems ○ Hypo/Hyper Thyroidism ○ Vascular Disease	○ Mumps ○ Measles ○ Chicken Pox ○ Arthritis ○ Suicide

Any family history of serious illnesses / Tiene una historia de enfermedad familiar: Cancer Diabetes Heart Disease Gout

If so, who / Si es certo, quien: _____

- Are you taking any nutritional supplements? / Esta tomando suplementos nutritivos? _____
- Do you consume? (if so, list amount) / Usted consume? (si es cierto, anota cuanto)
- Cigarettes _____ Coffee_____ Alcohol_____

Are you currently experiencing any of the following? / Estas experimentando alguno de lo siguiente ?

HEENT	Cardio Respiratory	Gastrointestinal	Gentourinary	Neuropsych
○ Hair Loss / Scalp Pain ○ Difficulty w/ Vision ○ Double Vision ○ Diffculty Hearing ○ Ringing of Ears ○ Difficulty Breathing ○ Nasal Discharge ○ Difficulty Chewing ○ Difficulty Swallowing	○ Chest Pain ○ Left Arm Pain ○ Palpations ○ Coughing ○ Wheezing ○ Short Breath ○ Asthma ○ Allergy ○ Discharge ○ Fatigue	○ Abdomen Pain ○ Diarreha ○ Bloating ○ Constipation ○ Gerd ○ Pencil Stool ○ Liver Problem ○ Loss / Gain of Weight ○ Cramps ○ Rash Skin	○ Discharge ○ Hesitancy ○ Frequency ○ Bladder Control ○ Pain urination ○ Sexual Dysfunction	○ Dizziness ○ Confusion ○ Depression ○ Fatigue ○ Numbness ○ Tingling ○ Sweats ○ Fever ○ Memory Loss ○ Suicide ○ Abuse

- List Any Allergies/ Alergias:_____
- Any pacemakers, stimulators or internal hardware? Example: Shunts, Dorsal Column Stim?_____
- Any Additional Comments / Comentario adicional:_____

Patient Signature: _____ **Date**: _____

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Patient / Plan Member Name:	Birth Date:	SSN:
Provider's Name:	Recipient's Name: **Integrated Chiropractic Healthcare, P.A**	
Provider's / Health Plan's address:		

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING: (FILL IN THE DATE OR THE EVENT, BUT NOT BOTH)

Date:	Event:
Purpose of disclosure:	

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes? [ ] Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. [✓] No, then you may check as many items below as you need.

Description	Dates	Description	Dates	Descriptions	Dates
[✓] All PHI in medical records [ ] Admissions Form [ ] Dictation Reports [ ] Physicians Orders [ ] Intake / Outtake [ ] Clinical Test [ ] Medication Sheets		[ ] Operative Info [ ] Cath Lab [ ] Special test/therapy [ ] Rhythm strips [ ] Nursing Info [ ] Transfer Forms [ ] ER Information		[ ] Labor / delivery sum [ ] OB nursing assess [ ] Postpartum flow sheet [ ] Itemized bill [ ] UB-92 [ ] Other: [ ] Other:	

I Understand that:

1. I May refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the
4. revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal
6. privacy regulations and may be re-disclosed.
7. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
8. I get a copy of this form after I sign it.

Will the recipient financial or in–kind compensation in exchange for using or disclosing this information? [ ] Yes [✓] No
If yes, describe:

I have read the above and authorize the disclosure of the protected health information as stated.

SIGNATURE OF PATIENT / GUARDIAN / PLAN MEMBER REP:	**DATE:**