Rambod Derakhshani DC FIAMA

Today's date: ____ /____ /_____

About You

First Name: _____ MI: _____
Last Name: _____ [ ] Male [ ] Female
Birthdate: _____/_____/_____ Age: _____ Email address:_____
Address: _____ Apt: _____ City: _____ State: _____ Zip: _____
Home #: _____Cell #: _____
Wk #: _____Ext: _____
Occupation: _____ Employer: _____ Marital Status: S M D W
# of children: _____ Spouse's Name: _____
(if minor) Parent or Guardian: _____
Who may we thank for referring you to our office:
_____

Insurance Information: *We will make a copy of your insurance card(s). However, please complete the following information.*
Are you the policyholder? **Y N**
Insurance Name:
_____Policyholder'sName_____
Birthdate: _____/_____/_____ Male/ Female
Policyholder's SS #: _____ Address: _____ Employer:
_____
Member ID#:_____Group #:_____

Reason For Visit
Please describe the pain/symptoms & its location:
_____

The pain is a result of: _____
When did the pain begin?: _____
Is the pain /symptom getting worse?: [ ] **Yes** [ ] **No**
is your pain /symptom Present / 75-100% of time / 50-75% of time / 25-50 % of time / 0 - 25% of time
Does pain keep you awake at night Yes No Does pain wake you up from sleep Yes No
Rate your Pain 0 1 2 3 4 5 6 7 8 9 10 (0 being no pain and 10 being excruciating)
Have you had this or a similar conditions in the past: [ ] **Yes** [ ] **No** If **YES**, explain: _____ Have you been treated by another physician for this condition? [ ] **Yes** [ ] **No** If **YES**, explain _____
Have you ever been treated by a chiropractor before:? [ ] **Yes** [ ] **No**

Name of your family doctor: _____ Family Doctor's #:_____

Health History

Habits: Cigarettes - [ ]**Yes** [ ] **No** Alcohol - [ ]**Yes** [ ] **No** Coffee - [ ]**Yes** [ ] **No**
Exercise - [ ]**Yes** [ ] **No** Are you pregnant: **Y** **N**
Are you taking any medications? If **YES,** list:

_____

_____

Do you have or ever had any of the following conditions or diseases?

Y **N** Heart Attack/Stroke **Y** **N** Cancer **Y** **N** Diabetes **Y** **N** Tuberculosis
Y **N** Frequent Neck Pain
Y **N** Psychiatric problems **Y** **N** Difficulty breathing **Y** **N** Sever/frequent headaches
Y **N** Sinus Problems
Y **N** Lower Back Problems **Y** **N** Fainting/seizures/epilepsy **Y** **N** Asthma
Y **N** Artificial bones/joints

Please list any other serious medical condition(s) you have or had:

_____
_____

List previous/past surgeries/treatments with dates:

_____
_____

Family History: (please circle) Headaches, Low Back Pain, Neck Pain, Other spinal problems, explain: _____

Assignment & Release

*I understand & agree that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand that this office will prepare any necessary reports & forms to assist me in making collection from the carrier & that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.

***As a courtesy to you we will verify your health care benefits for this office. You will then be responsible for any co pays and deductibles.**

*Your health insurance is a contract between you & the insurance carrier. In the "rare" event that your insurance company is in "bad faith" & after our office make every attempt to have all claims paid, we will have you, the patient, be responsible for contacting your insurance carrier to have the claims paid.

*If your insurance company has not paid within 120 days of billing, then you will be responsible to pay the balance due.

*If Collection efforts become necessary to enforce payment terms, the patient agrees to pay all collection costs, attorney's fees, & other costs associated with collecting this balance.

*I hereby authorize & release the doctor & whomever he/she assistants, to administer treatment, physical examination, x-rays studies, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or

any part of my patient record to an y person or corporation which is or may be liable under a contract to this office or to patient or to a family member or employer of the patient for all or part of the clinic's charge, including & not limited to hospital or medical services companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature

_____

Date: _____/_____/_____