



1619 E. Common St. #601  
New Braunfels, TX 78130  
(p) 830.626.3155 • (f) 888.279.5468

## Patient Profile

Full Name: \_\_\_\_\_ Jr/Sr  
Last First MI

Address: \_\_\_\_\_  
Street Address Apt/Unit  
\_\_\_\_\_  
City State Zip Code

Primary Phone: \_\_\_\_\_ H / M / B

Alternate Phone: \_\_\_\_\_ H / M / B

Social Security: \_\_\_\_\_ - -

Birth Date: \_\_\_\_\_ / /

Gender:  Male  Female

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Phone

Marital Status:  Single  Married  Widowed  Divorced

Do you have any dependents?  Yes  No

Are you a full-time student?  Yes  No

Do you have health insurance?  Yes  No If yes, list payor name: \_\_\_\_\_

Responsible Party:  You  Other If other, list name: \_\_\_\_\_



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## Chief Complaint Form

Reason for your visit:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did the symptoms begin?

\_\_\_\_\_

MM / DD / YYYY

Which word describes the frequency of your discomfort?

(select one)

- Constant                       Frequent  
 Intermittent                       Occasional

### For Women Only:

Most recent menstrual cycle:

\_\_\_\_\_

MM / DD / YYYY

Are you pregnant?

- Yes                       No

Which phrases best describe changes in your discomfort during the day? (select all that apply)

- Bending                       Getting Up                       Reading                       Turning head  
 Bowel Movements                       Lifting                       Sitting                       Urination  
 Coughing                       Lying Down                       Sleeping                       Walking  
 Daily Routine                       Pulling                       Sneezing                       Working  
 Driving                       Pushing                       Standing  
 Other \_\_\_\_\_

Approximate date of your most recent: (month / year)

Physical exam: \_\_\_\_\_ / \_\_\_\_\_

Spinal X-ray: \_\_\_\_\_ / \_\_\_\_\_

MRI: \_\_\_\_\_ / \_\_\_\_\_

Dental X-ray: \_\_\_\_\_ / \_\_\_\_\_

CT Scan: \_\_\_\_\_ / \_\_\_\_\_





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## Health History

Have you had or do you have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter:

- **N** if you have these conditions now
- **P** if you have had these conditions previously

<input type="checkbox"/> Headaches	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Feet/Hands Cold	<input type="checkbox"/> Constipation
<input type="checkbox"/> Tension	<input type="checkbox"/> Sudden Weight Loss	<input type="checkbox"/> Colitis
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Swelling joints	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Stomach upset
<input type="checkbox"/> Neck/Arm pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Belching
<input type="checkbox"/> Tingling in arms	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Tingling in legs	<input type="checkbox"/> Fever	<input type="checkbox"/> Gall bladder
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Weakness in arms	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Weakness in legs	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cancer
<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Depression	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Allergies	<input type="checkbox"/> Lights bother eyes	<input type="checkbox"/> Dizziness



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## Authorizations and Releases

### Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:

<http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial: \_\_\_\_\_

### Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial: \_\_\_\_\_

### Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial: \_\_\_\_\_

### Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of the third party payors. This assignment is irrevocable. Failure to fill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial: \_\_\_\_\_

### Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without the advanced notification required by this office.

Initial: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date