

CENTENNIAL WELLNESS CENTER

7910 W. Tropical Pkwy. Ste. 110 LV, NV 89149

(T) 702.458.2225 (F) 702.396.4536

P.I. NEW PATIENT FORM

PERSONAL INFORMATION

First _____ M.I _____ Last Name _____

DOB _____ Height _____ Weight _____ Gender Male Female

SSN _____ Marital Status Single Married Divorced Widowed

Employed Yes / No If yes, what is your occupation _____ Work Phone _____

How did you hear about us? Attorney Other (please specify) _____

CONTACT INFORMATION

Address _____ City _____ State _____ Zip _____

Email _____ Cell # _____ Alternate # _____

Emergency Contact Name _____ Phone # _____

CASE INFO

Due to accident Yes / No Attorney _____

Case Type Auto Accident Slip and Fall Other _____

Date of Injury _____ Time _____ Location _____

Did you go to the hospital Yes / No Where _____

Were X-rays taken Yes / No Were you transported by ambulance Yes / No

Present Medications/Conditions

Previous Surgeries and Dates

Allergies

Family Health History

Payment is expected at time of visit unless prior arrangements have been made. If you have health insurance, this is a direct assignment of benefits under your policy. This means you understand any remaining balance is your responsibility.

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signature _____ Date _____

Details

Please describe the accident: _____

You were the Driver / Passenger. If passenger, where were you seated? _____

Visibility Poor / Fair / Good

Were you wearing your seatbelt? Yes / No

Did your air bag go off? Yes / No

Did you strike anything in the vehicle? Yes / No If so, what did you hit? _____

Where were you struck? (Part of your body) _____

Did you see the accident coming? Yes / No

Were you dazed? Yes / No

Did you lose consciousness? Yes / No If yes, for how long? _____

Did you hit your head? Yes / No

Since the accident, have you had any problems sleeping? Yes / No

Have you lost time from work due to the accident? Yes / No If yes, how long? _____

Have you ever been involved in a previous accident? Yes / No If yes, what year(s) _____

Complaints

Please ONLY describe one complaint at a time, starting with the area in which you are experiencing the most pain.

Complaint 1: _____

Came on Immediately / Gradually Is it getting Better / Same / Worse

On a scale of 1-10, how much does it hurt? (10 being the worst) _____

How often does the pain come on? Intermittent Occasional Frequent Constant

How does it feel? (Circle all that apply) Dull Sharp Achy Spasm Throbbing Burning Numb Tingling

Does this pain radiate to any other part of your body? Yes / No If yes, where? _____

What increases the pain? (Circle all that apply) In the morning In the afternoon Lying down Bending forward

Bending Backwards Bending left Bending right Twisting left Twisting right Coughing Sneezing

Standing Lifting Sitting Heat Cold Rest

What makes the pain better? _____

Complaint 2: _____

Came on Immediately / Gradually Is it getting Better / Same / Worse

On a scale of 1-10, how much does it hurt? (10 being the worst) _____

How often does the pain come on? Intermittent Occasional Frequent Constant

How does it feel? (Circle all that apply) Dull Sharp Achy Spasm Throbbing Burning Numb Tingling

Does this pain radiate to any other part of your body? Yes / No If yes, where? _____

What increases the pain? (Circle all that apply) In the morning In the afternoon Lying down Bending forward

Bending Backwards Bending left Bending right Twisting left Twisting right Coughing Sneezing

Standing Lifting Sitting Heat Cold Rest

What makes the pain better? _____

Complaint 3: _____

Came on Immediately / Gradually Is it getting Better / Same / Worse

On a scale of 1-10, how much does it hurt? (10 being the worst) _____

How often does the pain come on? Intermittent Occasional Frequent Constant

How does it feel? (Circle all that apply) Dull Sharp Achy Spasm Throbbing Burning Numb Tingling

Does this pain radiate to any other part of your body? Yes / No If yes, where? _____

What increases the pain? (Circle all that apply) In the morning In the afternoon Lying down Bending forward

Bending Backwards Bending left Bending right Twisting left Twisting right Coughing Sneezing

Standing Lifting Sitting Heat Cold Rest

What makes the pain better? _____

Complaint 4: _____

Came on Immediately / Gradually Is it getting Better / Same / Worse

On a scale of 1-10, how much does it hurt? (10 being the worst) _____

How often does the pain come on? Intermittent Occasional Frequent Constant

How does it feel? (Circle all that apply) Dull Sharp Achy Spasm Throbbing Burning Numb Tingling

Does this pain radiate to any other part of your body? Yes / No If yes, where? _____

What increases the pain? (Circle all that apply) In the morning In the afternoon Lying down Bending forward

Bending Backwards Bending left Bending right Twisting left Twisting right Coughing Sneezing

Standing Lifting Sitting Heat Cold Rest

What makes the pain better? _____

Centennial Wellness Center

Doctor-Patient Relationship in Chiropractic

Informed Consent

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctors' procedures often depends on environment, underlying causes and physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other options as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctors of Chiropractic, gives the doctors permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctors, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctors of Chiropractic provides a specialized, non-duplicating health service. The Doctors of Chiropractic are licensed in a special practice and are available to work with any other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with one of the doctors before signing this statement of policy.

I have read and understand the foregoing.

SIGNATURE _____

DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand CENTENNIAL WELLNESS CENTER Notice of Privacy Practices.

Signature: _____

Printed Name: _____

Date: _____

INSURANCE/ATTORNEY INFORMATION

Your Attorney (if applicable) _____

Your Insurance (if applicable) _____

ASSIGNMENT OF BENEFITS

I hereby guarantee payment of all charges incurred for services rendered to me, _____
_____ (print name).

I also hereby assign and direct you to pay medical benefits under this claim directly to CENTENNIAL WELLNESS CENTER and/or Danielle Buda, D.C. I also hereby authorize CENTENNIAL WELLNESS CENTER and/or Danielle Buda, D.C to furnish from my records, any information requested by the insurance company in connection with the above assignment.

SIGNATURE _____

DATE _____

WITNESS _____

ATTORNEY

Patient _____ Date of Accident _____

I do hereby authorize Centennial Wellness Center to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to Centennial Wellness Center such sums as may be due and owing them for the medical service rendered me both by reason of this accident and by reason of any other bills that are due to Centennial Wellness Center and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect and fully compensate the doctors at Centennial Wellness Center. And I hereby further give a Lien on my case to the doctors against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney, or myself, as the results of the injuries for which I have been treated or injuries in connection.

I fully understand that I am directly and fully responsible to Centennial Wellness Center for all medical bills submitted by them for service rendered me and that this agreement is made solely for Centennial Wellness Centers additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

I agree to promptly notify the doctors at Centennial Wellness Center of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctors' office. I have been advised that if my attorney does not wish to cooperate in protecting the doctors' interest, the doctors will not await payment and may declare the entire balance due and payable.

DATED _____ SIGNATURE _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate the doctors at Centennial Wellness Center. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

DATED _____ ATTORNEY SIGNATURE _____





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PATIENT REQUEST FOR RECORDS

TO: _____ DATE: _____

ADDRESS: _____

FAX: _____

I hereby authorize the release of my medical records or copies of such and request that they be transferred to:

CENTENNIAL WELLNESS CENTER
7910 W. TROPICAL PKWY. STE. 110
LAS VEGAS, NV 89149

PATIENTS NAME: _____ DOB: _____

DATE OF RECORDS: _____ SSN: _____

PATIENTS SIGNATURE: _____