PRO SPINE & SPORT SOLUTIONS

Relieve pain. Restore function. Return to activity.

Patient Name _____ Birthdate _____ Sex: M / F

Address _____ City _____ State _____ Zip _____ Phone ( ) _____

Primary Language _____ Occupation _____ Employer _____

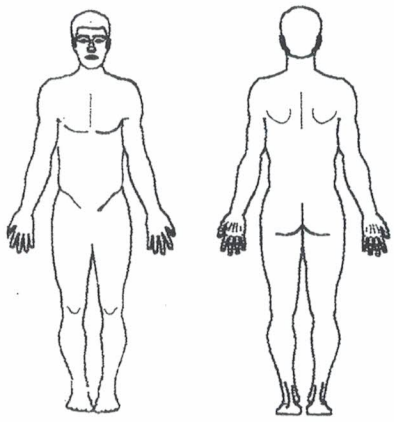
Work # ( ) _____ Address _____ City _____ State _____ Zip _____

Subscriber Name _____ Health Plan _____ Subscriber ID# _____ Group # _____

Spouse Name _____ Spouse Employer _____ City _____ State _____ Zip _____

Primary Care Physician Name _____ PCP Phone ( ) _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

Other _____

is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began _____

How Problem Began _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Abnormal Weight ____Gain ____Loss
☐ Alcohol/Drug Dependence
☐ Cancer/Tumor (Explain) _____
_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Diabetes
☐ Dizziness/Fainting
☐ Epilepsy/Seizures
☐ Fever (Now or recently)
☐ High Blood Pressure

☐ Marked Morning Pain/Stiffness
☐ Medications _____
_____
☐ Menstrual Problems
☐ Numbness in Groin/Buttocks
☐ Osteoporosis
☐ Other Health Problems (Explain) _____
_____
☐ Pain at Night
☐ Pain Unrelieved by Position or Rest

☐ Pregnant, # Weeks _____
☐ Prostate Problems
☐ Stroke (Date) _____
☐ Surgeries _____
_____
☐ Taking Birth Control Pills
☐ Tobacco Use - Type _____
Frequency _____/Day
☐ Urinary Problems
☐ Visual Disturbances

Family History: ☐ Cancer ☐ Heart Problems/Stroke ☐ Diabetes ☐ Rheumatoid Arthritis ☐ High Blood Pressure

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

5252 Balboa Ave, Suite 701 | San Diego, CA 92117 O: 858.384.6556 F: 858.225.8320 www.DrRumel.com

RUMEL LLANTADA, DC CCSP
5252 BALBOA AVENUE SUITE 701
SAN DIEGO, CA. 92117
(858)384-6556

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care and treatment.

I understand that I have the right to see and receive a copy of my health records.

I hereby request and consent to the performance of Chiropractic adjustments, physical examination, soft tissue procedures, physiotherapy and diagnostic x-rays. If warranted, on me should I elect to seek care from Dr. Llantada's office. I consent and allow Dr. Llantada to evaluate and treat me on an emergency basis should I be in a condition where I am not able to authorize consent.

I understand, that as in the practice of medicine, there are some risks to treatment in the practice of Chiropractic care, including, but not limited to, sprains, disc injuries, dislocations, fractures and stroke (in extremely rare cases). I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor feels at the time, based on the facts then known, are in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow Dr. Rumel Llantada to perform such. I intend this consent to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____ _____

Patient/ or Legal Representative Signature Date

RUMEL LLANTADA, DC CCSP
5252 BALBOA AVENUE SUITE 701
SAN DIEGO, CA. 92117
drrumel.office@gmail.com
(858)384-6556

FINANCIAL AGREEMENT
HEALTH INSURANCE

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office I would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage and Financial Responsibility

Most insurance companies cover Chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible, percentage of coverage for Chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balance in this office. We will do our best to verify your insurance coverage, but verification of coverage is still not a guarantee of payment and we will bill your insurance company(ies) in a timely manner for you.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to my physician Dr. Rumel Llantada, DC. I also hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payments directly to Dr. Rumel Llantada, DC for medical services rendered to myself and/or my dependents. I understand I am responsible for any amount not covered by my insurance.

Release of Information

I hereby authorize Dr. Rumel Llantada, DC (1) to release any medical information necessary to insurance carriers regarding my illness and treatment for the purpose of processing insurance claims generated in the course of examination and/or treatment. I also allow a photocopy of my signature to be used to process insurance claims for the period of 24 months.

A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature **Date**