R.O.C. Patient and Insurance Information

CLIENT INFORMATION

Last name:	First name:	Date:
Email:	Marital status: S M D W	Birth date:

Address: [Address/P.O. Box, Apartment no., City, State, ZIP code:]

Social Security no.:	Home phone no.:	Work phone no.:
Driver's License no.:	Cell phone no.:	Beeper:
Spouses name:	Age range of children:	Referred by:
Employer:	Occupation:	

Address: [Address/P.O. Box, Apartment no., City, State, ZIP code:]

HEALTH INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Carrier:

Insurance company phone no.:	Patient Relationship to the insured: Self Spouse Child Other
Policy no.:	Group no.:

Address: [Address/P.O. Box, City, State, ZIP code:]

IF YOU ARE COVERED UNDER ANOTHER PERSONS INSURANCE, PLEASE COMPLETE

Name of insured:	Sex:	Phone no. of insured:	Birth date:

Address: [Address/P.O. Box, Apartment no., City, State, ZIP code:]

Patient's relationship to subscriber:

Insured employer:

Employer's Address: [Address/P.O. Box, City, State, ZIP code:]

Employer phone no.:	Plan name:

AUTO ACCIDENT INSURANCE

Policy no.:	Carrier:

Address: [Address/P.O. Box, City, State, ZIP code:]

Person to contact *and* phone number:	Claim no.:
Date of accident:	Patient Relationship to the insured: Self Spouse Child Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize R.O.C. Patient and Insurance Information or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

HEALTH QUESTIONNAIRE

River Oaks Chiropractic & Body Works

Patient: _____ **Date:** _____

Please check each of the conditions that you are currently experiencing.

Musculoskeletal Systems
- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones

Gastrointestinal System
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

Cardiovascular Respiratory
- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

Female
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps in breast

Are You Pregnant?
- ☐ Yes
- ☐ No

Nervous System
- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Eye, Ear, Nose & Throat
- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficulty breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain
- ☐ Difficult speech

Genitourinary System
- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize River Oaks Chiropractic and Body Works to release my medical information to my health, automotive, or any other insurance company providing medical coverage benefits to me for the completion of my insurance form(s).

I hereby authorize and request payment of any medical benefits to which I may be entitled from any insurance policy, including automobile personal injury protection, be made payable to and forwarded to River Oaks Chiropractic and Body Works, 2400 Augusta Dr., Suite 210, Houston, TX 77057.

_____ _____

Patients Signature Date

River Oaks Chiropractic & Body Works

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

By signing this form, you are only acknowledging that you have been provided our Notice.

_____	_____
Name	Date of Birth
_____	_____
Signature of Patient or Authorized Representative	Date

River Oaks Chiropractic

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date