

Rambod Derakhshani DC FIAMA

Today's date: ____ / ____ / ____

About You

First Name: _____ MI: _____ Last Name: _____ [] Male [] Female
SS #: _____ 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's Name: _____ Birthdate: ____ / ____ / ____ Male/ Female
Policyholder's SS #: _____ Address: _____ Employer: _____
Member ID#: _____ Group #: _____

Do you have secondary insurance coverage: Y N If YES, please complete this section.

Insurance Name: _____ Policyholder's Name: _____ Birthdate: ____ / ____ / ____ Male/ Female
Policyholder's SS #: _____ Address: _____ Employer: _____

Reason For Visit

Please describe the pain & its location: _____ The pain is a result of: _____

When did the pain begin?: _____ Is the pain getting worse?: [] Yes [] No

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 any 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: _____/_____/_____