SEACREST
Health & Wellness Center

Dr. Will Rogers, DC, DACNB
Dr. Dean Peppard, DC
www.SeacrestHWC.com

714-821-4265
www.SeacrestHWC.com

PATIENT INFORMATION

Name:______________________________ ☐M ☐F

Date of Birth:____/____/_______ Age:____ __

SSN: _____ - ____ - _____ (full number for PI/WC)

Driver's License:________________ State:______

Cell Phone: (_____)_________________

Home Phone: (_____)_________________

Email:______________________________________

Street Address:_________________________________

City:___________________, State____ Zip:_______

Marital Status: ________________________________

Emergency Contact:_____________________________

Emergency Phone:______________________________

How did you hear about us?

____

EMPLOYMENT INFORMATION

Occupation:_________________________________

Employer:___________________________________

Phone:______________________________________

Address__________________________ Suite:____

City:___________________, State____ Zip:_______

INSURANCE INFORMATION

Please check one/any of the following:

☐ I have *Medicare Part B*. Please hand your **Medicare card** and **driver's license** to the front desk.

☐ I would like to bill my *insurance*. Please provide us with your **insurance card and driver's license.**

☐I I am seeking help due to an injury from a car accident.

☐I I am seeking help due to an accident in my workplace.

☐I I wish *not* to bill any insurance company. (We still need your **driver's license**)

For Staff Use Only

Patient #:_______________ **Type:** Insurance / PI / Medicare/Self-Pay Date:_____________

☐ New ☐ Updated ☐ DL ☐ Insurance Card ☐ NP Letter ☐ Referral TY

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CHIEF COMPLAINT(S)

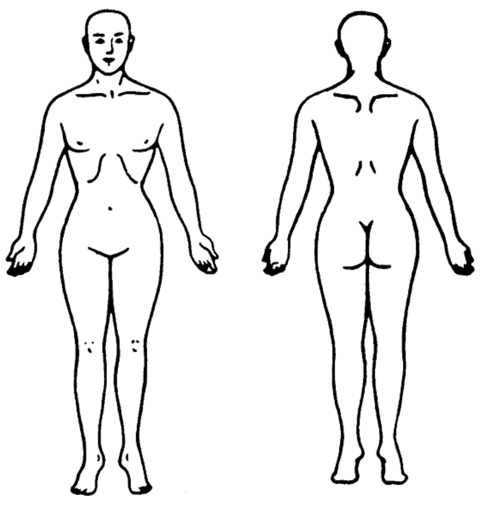
Please describe the problem(s) in your own words and place in order of priority with most important first:

____

____

____

If symptoms are pain related, please indicate the approximate location(s) of the pain:



Please circle a # 0-10, 0 being no pain, 10 being worst possible pain)

My pain is *generally*: **[0 1 2 3 4 5 6 7 8 9 10]**

My pain *right now*: **[0 1 2 3 4 5 6 7 8 9 10]**

Pain quality (please check any that apply):

☐ **Sharp/Stabbing** ☐ **Dull/Achy**

☐ **Tingling** ☐ **Numbness**

☐ **Burning** ☐ **Stiffness**

When did symptoms begin? ___/___/______ Sudden Onset or Gradual?:______________________________________

Since onset, symptoms have gotten: ◻ **Better** ◻ **Worse** ◻ **Same** Symptom Frequency: ◻ **Constant** ◻ **Intermittent**

Do you know what caused the problem(s)?: ◻ **Y** ◻ **N** If yes, explain:

____

Does anything *relieve* symptoms? ◻ **Y** ◻ **N** If yes, explain: ____

____

Does anything *aggravate* symptoms? ◻ **Y** ◻ **N** If yes, explain: ____

____

Has this problem affected normal sleeping pattern? ◻ **Y** ◻ **N** If yes, explain: ______________________________

____

How does this problem affect…
Home Life: ____
Work/School Life: ____
What is your ultimate goal for treatment? (e.g. "Play golf again" or "Hold my grandchild"):

____

____

What is your commitment level to achieving this goal (rate #1-10, 10 being most commited): ______

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SYMPTOMS CHECKLIST

Please check if appropriate.

Orthopedic & Musculoskeletal

□ "Clunk" Sounds
□ Neck Pain
□ Upper Back Pain
□ Lower Back Pain
□ Jaw Pain
□ Clicking in Jaw
□ Face Pain
□ Chest Pain
□ Stomach Pain
□ Range of Motion Problems
□ Radiating Pain
□ Muscle Spasms
□ Bruise/Contusion to: ______________________
□ Abrasion/Scrape to: ______________________
□ Other: ______________________________________
□ Other: ______________________________________

□ Shoulder Pain → □ **Left** □ **Right**
□ Upper Arm Pain → □ **Left** □ **Right**
□ Elbow Pain → □ **Left** □ **Right**
□ Forearm Pain → □ **Left** □ **Right**
□ Wrist Pain → □ **Left** □ **Right**
□ Hand Pain → □ **Left** □ **Right**
□ Hip Pain → □ **Left** □ **Right**
□ Upper Leg Pain → □ **Left** □ **Right**
□ Knee Pain → □ **Left** □ **Right**
□ Lower Leg Pain → □ **Left** □ **Right**
□ Ankle Pain → □ **Left** □ **Right**
□ Foot Pain → □ **Left** □ **Right**
□ Numb/Tingling Arm/Hand → □ **Left** □ **Right**
□ Numb/Tingling Leg/Foot → □ **Left** □ **Right**
□ Weakness Arm/Hand → □ **Left** □ **Right**
□ Weakness Leg/Foot → □ **Left** □ **Right**

Neurological

□ Memory Problems
□ Stress/ Anxiety
□ Head Trauma
□ Balance/Walking Issues
□ Depression/Sadness
□ Frustration/ Irritability
□ Visual Disturbances
□ Nausea/Vomiting
□ Pupils Different Sizes
□ Change in Sexual Function
□ Apathy (Don't Care)

□ Attention Problems
□ Learning Disabilities
□ Speech Problems
□ Brain Fog
□ Abnormal Fatigue
□ Reading/Writing Problems
□ Sleep Disruption
□ Mood Swings
□ Personality Change
□ Reduced Confidence
□ Hearing Problems

□ Dizziness/Vertigo
□ Headaches/ Migraines
□ Movement Problems
□ Hyperactivity
□ Confusion/ Disorientation
□ Panic Attacks
□ Anti-Social Tendencies
□ Appetite Change
□ Difficulty Making Decisions
□ Feeling of Helplessness
□ Impatience

□ Other: ____
□ Other: ____

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HEALTH HISTORY

Allergies	☐Past	☐Present		Rheumatic Fvr	☐Past	☐Present	
Asthma	☐Past	☐Present		Scarlet Fvr	☐Past	☐Present	**Height:** __________
Anemia	☐Past	☐Present		Sleep Prob	☐Past	☐Present	
Appendicitis	☐Past	☐Present		Skin Prob	☐Past	☐Present	**Weight:** __________
Cancer	☐Past	☐Present		Psychiatric	☐Past	☐Present	
Cold Sores	☐Past	☐Present		Stomach Prob	☐Past	☐Present	**Daily water intake?**
Diabetes	☐Past	☐Present		Heart Prob	☐Past	☐Present	____________ **oz**
Dizziness	☐Past	☐Present		Lung Prob	☐Past	☐Present	
Polio	☐Past	☐Present		Measles	☐Past	☐Present	
Epilepsy	☐Past	☐Present		Mumps	☐Past	☐Present	
TB	☐Past	☐Present		Pneumonia	☐Past	☐Present	
Ulcers	☐Past	☐Present		Pleurisy	☐Past	☐Present	

Describe any other conditions that are not listed above: ____
____
____

Describe any **yes** responses (ex: types of allergies, heart conditions, etc): ______________________
____
____

Have you ever suffered from a concussion? ☐ **Y** ☐ **N** If yes, when? ______________________

Describe any other major accidents or injuries (especially to the head, neck or back):
____

Please circle any applicable past surgeries: ☐ **Tonsils** ☐ **Appendix** ☐ **Hernia** ☐ **Prostate** ☐ **Hysterectomy**

☐ **Other**: ____

Please list any prescription or over-the-counter medications you are currently taking:
____
____
____
____

Have you ever been on disability? ☐ **Y** ☐ **N** If yes, when? __________________________________

Exercise Frequency:	☐Never	☐Seldom	☐Often	☐Frequent
Smoking Habits:	☐Never	☐Seldom	☐Often	☐Frequent
Alcohol Habits:	☐Never	☐Seldom	☐Often	☐Frequent
Coffee Habits:	☐Never	☐Seldom	☐Often	☐Frequent

Please indicate whether any family relative has ever had the following, and indicate who.

☐ Cancer ______________	☐ Tuberculosis______________	☐ Anemia ______________
☐ Diabetes______________	☐ Heart Disease______________	☐ Gout______________
☐ Seizures ______________	☐ Suicide______________	☐ Arthritis______________

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INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and am informed that results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to: self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____ ______________________

Signature of Patient or Legal Guardian Date

ERISA AUTHORIZATION OF BENEFITS

For good and valuable consideration, I ______________________________________, do hereby designate, authorize and convey to Seacrest Health and Wellness Center, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee health care benefit plan; and b) the right and ability to act on my behalf to pursue such claim, right or chose in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR§2560.5031(b)(4)) with respect to any medical or other health care expense incurred as a result of the services I received from the above-named center and, to the extent permissible under the law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

____ ______________________

Signature of Patient or Legal Guardian Date

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Patient Name ______________________________ Date ______________

Initial	FINANCIAL RESPONSIBILITY & CANCELLATION POLICY
↓	By accepting services or products from SHWC, you are agreeing that you are financially responsible for such services or products. ***Fees are due at time of service, regardless of insurance. We are out of network with all insurance companies.*** If you miss your appointment without 24-hour prior notice, we reserve the right to charge for the time we had reserved for you. **Cancellation fee is 50% of the service fee.** You, and not your insurance company or attorney, are directly responsible for any cancellation fees incurred. Fees will be collected upon your next visit to the office or billed to your address.
Initial	**BILLING POLICY**
↓	We can either give you an itemized statement which you can submit to your insurance company, or have our outside billing service bill it for you. ***Using our outside billing service it is possible to not receive a response from the insurance company for up to 90 days.*** Your insurance company will send the reimbursement to our office and we will refund your money or apply the balance in a prepayment arrangement with you. The billing service charges 7% on all funds collected from the insurance company. This charge is deducted from the refund given by the insurance company. The 7% charge does not apply to Medicare billing as it is federally mandated, but will apply to secondary insurance. ***There is no guarantee that insurance will reimburse, even with benefit verification.***
Initial	**PRIVACY NOTICE**
↓	As required by the Privacy Regulations, SHWC **may not use or disclose** your protected health information without your authorization. In order to provide you with maximum care, we might need to discuss your case within our office or other outside consultant resources. We keep your health information safe and separate from your financial information. You can revoke or change this authorization at anytime by sending a written notice to our office. Our full *HIPPA Privacy Notice* is available for you and is posted in our office; Feel free to ask our staff any question regarding that matter. By signing here, you will provide SHWC your authorization to disclose your healthcare information for the purposes of treatment, payment and healthcare operations as described in the *Privacy Notice.* You may authorize us to share your information with someone by designating that person and naming them here: Name: ______________________________. Relationship: ______________________.
Initial	**PHOTO & VIDEO RELEASE**
↓	We often document our examinations for further analysis. We use standard recording equipment and there are no hidden recording devices in our facility. By signing here, you grant permission to the rights of your image, likeness and sound of your voice as recorded on audio or videotape without payment or any other royalties. This material may be used for internal review, pre/post analysis and in diverse educational settings within an unrestricted geographic area. There is no time limit on the validity if this release and it applies to photo, audio or video recording collected as part of our diagnostic and treatment process.

Signature: ______________________________ **Date:** ______________

CONSENT TO TREATMENT OF MINOR CHILD

Child's Name: ______________________________ **Date:** ______________

Guardian's Signature: ______________________________ **Relationship:** ______________