John C. Greene. D.C.

4200 Trabuco Road
Suite 180
Irvine, CA 92620

(949) 857-6631

PATIENT INFORMATION
FOR MEDICAL RECORDS

Date: _____

Patient _____ _____ Sex: M F
Last Name First Name M.I.

Birthdate _____ Marital Status- S M D Sep W Referred by _____

Driver's License #- _____ Social Security #- _____

E-Mail _____ Cell Phone _____

Home Address _____ Home Phone _____

City _____ Zip _____ Occupation _____

Employer _____ Work Phone _____

Address _____ City _____ Zip_____

Parent (if minor) / Spouse _____ Relation _____

Social Security # _____ Birthdate _____

Employed by _____ Work Phone _____

Address _____ City _____ Zip_____

Emergency Contact (Name)_____ Relation _____

Address _____City _____ Phone (W)_____(H)_____

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. _____and whomever he/she may designate as his/her assitant(s) to perform diagnostic tests including, but not limited to radiographs, range of motion, orthopedic and neurological testing and to administer treatment as is appropriate. Such treatment may include but not be limited to spinal manipulative therapy, soft tissue therapy, exercise therapy and physiological therapeutic procedures including, but not limited to, ultrasound and electrical muscle stimulation. All health care procedures have some inherent risk and the significant risks associated with chiropractic care are estimated to occur between one in one million to one in five million treatments. I have reviewed these risks and have decided to undergo treatment with this doctor.

Patient's signature_____Date_____

If you have any questions about the above informed consent please discuss them with your doctor.

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize _____D.C. and whomever he/she may designate as his/her assistant(s). To perform diagnostic tests, including but not limited to radiographs and to administer treatment as he/she deems necessary to my son/daughter, (name) _____

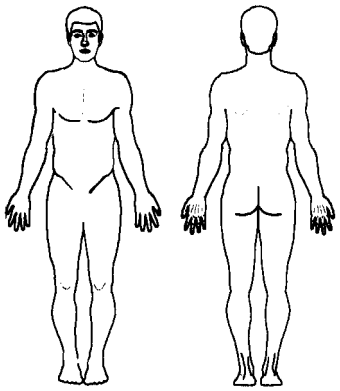
Patient's signature _____Date_____

❑ *John C.* **Greene.** ***D.C.***

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #- _____ Driver Lic. #- _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #- _____ Group #- _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

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



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT **BEGAN:**

_____
_____
_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A
DATE 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? ☐ 0 – 25% ☐ 26-50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications: _____
☐	☐	Cancer/Tumor			_____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma			

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that 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 provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____

John C. **Greene.** ***D.C.***

Insurance Information and Verification

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize _____(INS CO) to pay by check the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay in a current manner any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information to this clinic is correct and complete. Further, I understand I am to notify this office immediately if this information changes in any way, is terminated or results in COBRA benefits.

Patient's signature _____ Date _____

AUTHORIZATION FOR PATIENT CONTACT

I authorize the doctor and the doctor's office staff to contact me at my work and/or at my home and/or at my cell contact numbers. Further, I understand I am to notify this office if my contact information changes.
I would prefer to be called at ☐Home ☐Work ☐Cell

Patient's signature _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the doctor and/or the doctor's staff has provided me with a paper copy of Notice of Privacy Practices, or an electronic copy of the Notice of Privacy Practices, or has offered the opportunity to read the Notice of Privacy Practices. I understand I may request a copy of the Notice at any time.

Patient's signature _____ Date _____

INSURANCE INFORMATION - Card Provided Yes / No The following to be filled out if there is no card available:

Primary Insurance:

Insured Name _____ Soc. Sec # _____ DOB _____

Patient Name _____ Self ___ Spouse ___ Child ___ DOB _____

Employer _____ Phone _____

Insurance Co. _____ Policy # _____ Group# _____

Billing Address: _____ Phone _____

_____

_____