Welcome to **Morales Holistic Health Center**

Date:

Type of visit: ☐Chiropractic ☐Acupuncture ☐Rehabilitation ☐Med-Legal ☐Other:

Intake Sheet

Patient Information

First Name	Middle Initial	Last Name
Address		City, State, Zip
Home Phone ( )	Cell Phone ( )	Best time and place to reach you:
Date of Birth	Age	Sex: ☐Male ☐Female
Social Security Number		

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____ years ☐Other_____

Email	By providing us with your email, you will receive our bi-monthly newsletter containing healthy tips, clinic news, and complementary medicine updates. If you do not wish to receive the newsletter, it is easy to unsubscribe.
Employer/School	Occupation
Employer's / School's Address	Employer's / School's Phone Number:
Spouse's Name	Spouse's Birthdate / Spouse's SSN
Spouse's Employer	Spouse's Phone Number
Whom may we thank for referring you?	

IN CASE OF EMERGENCY, CONTACT:	Relationship	Home Phone ( )	Cell Phone ( )

Insurance

Who is responsible for this account?	Relationship to Patient

Insurance Co.	Member ID#	Group #
Is patient covered by additional insurance? ☐Yes ☐No If yes, Insurance Co. Name:	Secondary Insurance Member ID#	Secondary Insurance Group #

Secondary Insurance Subscriber's Name	Subscriber's SSN	Subscriber's Birthdate	Relationship to Patient

Assignment and Release

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ Date:_____ Relationship to Patient:_____

Signature Print

Accident Information

Is condition due to an accident? ☐Yes ☐No	Date of accident _____/_____/_____	Type of accident ☐Auto ☐Work ☐Home ☐Other
To whom have you made a report of your accident? ☐Auto Insurance ☐Employer ☐Worker Comp. ☐Other_____		Attorney Name (if applicable):

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

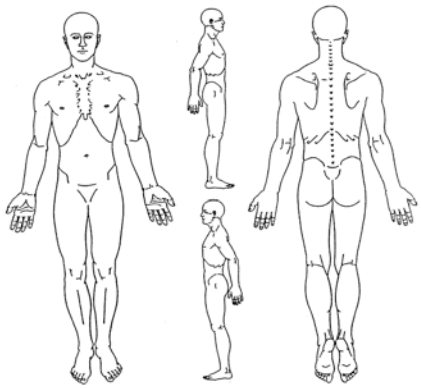
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down



www.moralesholistic.com
Pasadena 935 E Green St | 626.796.4141
Downey 8358 Florence Ave | 562.622.4444

PATIENT'S NAME _____

HEALTH HISTORY

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic
☐Acupuncture ☐None ☐Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes	☐No	Diabetes	☐Yes	☐No	Liver Disease	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Alcoholism	☐Yes	☐No	Emphysema	☐Yes	☐No	Measles	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Allergy Shots	☐Yes	☐No	Epilepsy	☐Yes	☐No	Migraine Headaches	☐Yes	☐No	STD	☐Yes	☐No
Anemia	☐Yes	☐No	Fractures	☐Yes	☐No	Miscarriage	☐Yes	☐No	Stroke	☐Yes	☐No
Anorexia	☐Yes	☐No	Glaucoma	☐Yes	☐No	Mononucleosis	☐Yes	☐No	Suicide Attempt	☐Yes	☐No
Appendicitis	☐Yes	☐No	Goiter	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Arthritis	☐Yes	☐No	Gonorrhea	☐Yes	☐No	Mumps	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Asthma	☐Yes	☐No	Gout	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	Heart Disease	☐Yes	☐No	Pacemaker	☐Yes	☐No	Tumors, Growths	☐Yes	☐No
Breast Lump	☐Yes	☐No	Hepatitis	☐Yes	☐No	Parkinson's Disease	☐Yes	☐No	Typhoid Fever	☐Yes	☐No
Bronchitis	☐Yes	☐No	Hernia	☐Yes	☐No	Pinched Nerve	☐Yes	☐No	Ulcers	☐Yes	☐No
Bulimia	☐Yes	☐No	Herniated Disk	☐Yes	☐No	Pneumonia	☐Yes	☐No	Vaginal Infections	☐Yes	☐No
Cancer	☐Yes	☐No	Herpes	☐Yes	☐No	Polio	☐Yes	☐No	Whooping Cough	☐Yes	☐No
Cataracts	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Prostate Problem	☐Yes	☐No	Other _____		
Chemical Dependency	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Prosthesis	☐Yes	☐No	_____		
						Psychiatric Care	☐Yes	☐No	_____		
Chicken Pox	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No			

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking Packs/Day _____
- ☐ Alcohol Drinks/Week _____
- ☐ Coffee/Caffeine Drinks Cups/Day _____
- ☐ High Stress Level Reason _____

Are you pregnant? ☐Yes ☐No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS
Pharmacy Name _____		
Pharmacy Phone (_____) _____		

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PATIENT'S NAME _____

Morales Holistic Health Center

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Please read and initial by each section, then sign and print your name at the bottom of this form.

Informed Consent for Chiropractic Treatment and Care

_____ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and/or diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor, associate doctor or intern(s), affiliated with Morales Holistic Health Center.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks of 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. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts the known, and is in my best interest.

I have read, or have had read to me, the above consent. By signing below, I agree to the above and allow the doctor, associate or intern affiliated with Morales Holistic Health Center to perform such. 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.

Acknowledgement of Financial Responsibility

_____When provided the necessary insurance/attorney information prior to an appointment, the staff of Morales Holistic Health Center (MHHC) makes every attempt to verify patient's coverage. In addition, the staff will gladly file claims on behalf of the patient. The insurance carrier will review the claim and accept or deny coverage as they deem appropriate. Should the insurance company/attorney deny coverage, it is the patient's responsibility to pay any and all of the balance due to MHHC. To be better prepared, patients should attempt to know their coverage including deductibles, co-pays and non covered services prior to receiving services. The staff of MHHC can give you a general idea of what may or may not be covered by your insurance plan before seeing the doctor. However, we cannot always know for certain what services will be provided by the doctor before the examination as what we are quoted is an estimate of coverage.

I understand that I am financially responsible to the participating practitioner, Morales Holistic Health Center, if services recommended are not covered under my health plan, if charges for services exceed my plan's maximum benefit or if my employment status has been altered or my insurance terminated.

Appointment Policy

_____At MHHC, it is our goal to provide you with your first choice when scheduling an appointment and to keep waiting time down to a minimum. In our efforts to do so, this office reserves the right to charge for missed appointments and those cancelled without **24 hours notice**. We understand that occasionally there are circumstances out of your control that may prevent you from arriving on time to your appointment. In such cases, we will do our best to accommodate you on the same day of your scheduled appointment.

By signing below, I acknowledge that I have read, understand and agree to the above information.

_____	_____	_____
Patient Name (Please Print)	Patient or Guardian Signature	Date

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND GENERAL HEALTH CARE OPERATIONS

1. Morales Holistic Health Center (MHHC) Practices Privacy Notice has been provided to me prior to my signing the consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI) necessary for the MHHC to provide treatment to me, and also necessary to obtain payment for the treatment and to carry out its health care operation. MHHC explained to me the Privacy Notice prior to signing this Consent.
2. MHHC (the practice) reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders will be used by MHHC: a) A postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the telephone.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the practice to conduct specific health operations.
5. I understand that I have a right to request that MHHC restrict how my PHI is used and/or disclosed to carry out treatment payment and/or health care operation. However, the practice is not required to agree to any restriction that I have requested.
6. If the practice agrees to a requested restriction, then the restriction is binding on the practice.
7. I understand that this consent is valid for seven years. I further understand that I have a right to revoke this consent in writing at any time for all future transactions, with the understanding that nay such revocation shall not apply to the extent that MHHC (the practice) has already taken action in reliance o this consent.

I understand that I could revoke this consent at any time and that MHHC, or the Practice, has the right to refuse to treat me.

I have read and understood the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual	Signature of Individual
Signature of Legal Representative (e.g., Attorney-in-fact, Guardian or parent of minor)	Relationship
Date Signed	Witness

ALL PATIENTS AND/OR LEGAL REPRESENTATIVES ARE ASKED TO READ THEN SIGN IN AGREEMENT UPON BEING ACCEPTED AS A PATIENT OF *MORALES HOLISTIC HEALTH CENTER* OR THE PRACTICE.

Morales Holistic Health Center