VANGUARD
Spine & Sport

New Patient Intake

*Patient Name*_____ *Date:* _____

Email: _____*SS #/SIN*_____ *DOB*_____ ☐ *Male* ☐*Female*

*Home phone*_____ *Cell Phone* _____

Check appropriate Box: ☐*Minor* ☐*Single* ☐*Married* ☐*Divorced* ☐*Widowed* ☐*Separated*

Patient's Address _____*City* _____ *State*_____ *Zip*_____

Employer Name: _____

*Spouse or Patient's Guardian name*_____ *Spouse's Employer*_____

Whom may we thank for referring you? _____

*Person to contact in case of an emergency*_____ *Phone*_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian *Date*

Responsible Party

Name of The Person responsible for this account _____*Relationship to Patient* _____

Address _____*Home Phone* _____

E-Mail _____*Cell Phone* _____

Driver's License # _____ *Date of Birth:* _____

Is the person currently a patient at our office? ☐ *Yes* ☐ *No*

Do you have any Medical insurance? ☐ *Yes* ☐ *No* *if yes, complete the following:*

*Name of the insured*_____ *Relationship to patient*_____

*Birthdate*_____ *SS#/SIN*_____

Employer

*Name of Employer*_____ *Work Phone* _____

*Address of Employer*_____

Insurance Information

*Insurance Company*_____ *Group #*_____ *ID#* _____

Ins. Co. Address _____ *City* _____ *State* _____ *Zip*_____

PLEASE BRING COPY OF YOUR DRIVER'S LICENSE AND INSURANCE CARD.

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ***Vanguard Spine & Sport*** *as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that* ***have been or will be*** *rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.*

Signed this ____ day of _____, 20 ____. *X_____*
(patient signature)

X_____ *X_____*
(signature of Guardian if applicable) *(please print patient name)*

Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint: _____

History of Present illness:

Location: _____ ***Quality:*** _____
(Where is the pain/problem?) *(Example: normal vs abnormal color, activity, etc..)*

Severity: _____ ***Duration:*** _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?) *(How long have you had this pain/ problem? When did it start?)*

Timing: _____ ***Context:*** _____
(Does the pain/problem occur at a specific time?) *(Where were you at the onset of this pain/problem?)*

Associated Signs/Symptoms _____ ***Modifying Factors*** _____
_____ _____
(What other associated problems have you been having?) *(What makes the pain/problem worse or better? Have you had previous episodes?)*

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles……..……NO YES	*Anemia…… NO YES*	*Back Trouble……NO YES*	*Hepatitis……..NO YES*
Mumps…….…… NO YES	*Bladder Infection…… NO YES*	*High Blood Pressure…..…..NO YES*	*Ulcer……..……NO YES*
Chicken Pox…….. NO YES	*Epilepsy…… NO YES*	*Low Blood Pressure…..…..NO YES*	*Kidney Disease…….NO YES*
Shingles……..… NO YES	*Migraine Headaches…. NO YES*	*Hemorrhoids……NO YES*	*Thyroid Disease……..NO YES*
Whooping Cough…. NO YES	*Tuberculosis…… NO YES*	*Date of Last Chest X-Ray_____*	*Bleeding Tendency…….NO YES*
Scarlet Fever…….. NO YES	*Diabetes…….. NO YES*	*Asthma……NO YES*	*MRSA……..NO YES*
Diphtheria……..… NO YES	*Cancer……..… NO YES*	*Hives of Eczema……..NO YES*	*Any other Disease……..NO YES*
Small Pox……. NO YES	*Polio…….. NO YES*	*AIDS & HIV……..…NO YES*	*(Please list):*
Pneumonia……..…. NO YES	*Glaucoma……..…. NO YES*	*Infectious Mono……NO YES*	_____
Rheumatic Fever….. NO YES	*Hernia……..…. NO YES*	*Bronchitis……..…..NO YES*	
Arthritis……..…. NO YES	*Blood or Plasma*	*Mitral Valve Prolepses…….NO YES*	_____
Venereal Desease… NO YES	*Transfusion……..…..NO YES*	*Stroke……..NO YES*	

Previous Hospitalizations/Surgeries/Serious Illnesses *When?* *Hospital, City, State*

_____ _____ _____

_____ _____ _____

Allergies(include to meds or non-meds [EX: Seasonal and Food]):

_____

Medication: *(include nonprescription)*

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: _____

Patient Social History:

Marital Status	*Single: _____*	*Married: _____*	*Separated: _____*	*Divorced: _____*	*Widowed: _____*
Use of Alcohol	*Never: _____*	*Rarely: _____*	*Moderate: _____*	*Daily: _____*	
Use of Tobacco	*Never: _____*	*Rarely: _____*	*Moderate: _____*	*Daily: _____*	
Use of Drugs	*Never: _____*	*Type/Frequency: _____*			
Excessive Exposure At home or at work to:	*Fumes: _____*	*Dust: _____*	*Solvents: _____*	*Airborne Particles: _____*	*Noise: _____*

CLINICIAN SIGNATURE: _____ ***DATE REVIEWED:***_____

PATIENT NAME: _____ ***DATE:***_____

*Name:*_____ *DOB* _____ *Date:*_____

Family Medical History:

	Age	*Disease*	*If Deceased, Cause Of Death*
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		***Muscular/Skeletal***	
Vision Changes	*1 2 3 4 5*		
Asthma	*1 2 3 4 5*	*Muscle Aches*	*1 2 3 4 5*
Stuffy Nose	*1 2 3 4 5*	*Fibromyalgia*	*1 2 3 4 5*
Hay Fever	*1 2 3 4 5*	*Arthritis*	*1 2 3 4 5*
Sore throat	*1 2 3 4 5*	*Joint Pain*	*1 2 3 4 5*
Chronic Cough	*1 2 3 4 5*	*Low Back Pain*	*1 2 3 4 5*
Chest Congestion	*1 2 3 4 5*	*Neck Pain*	*1 2 3 4 5*
Frequent Sneezing	*1 2 3 4 5*	*Wrist/Hand Pain*	*1 2 3 4 5*
Itchy/Watery Eyes	*1 2 3 4 5*	*Elbow Pain*	*1 2 3 4 5*
Drainage	*1 2 3 4 5*	*Shoulder Pain*	*1 2 3 4 5*
Earache or Ear Infection	*1 2 3 4 5*	*Hip Pain*	*1 2 3 4 5*
Itching	*1 2 3 4 5*	*Knee Pain*	*1 2 3 4 5*
Hoarseness	*1 2 3 4 5*	*Ankle/Foot Pain*	*1 2 3 4 5*
Shortness of Breath	*1 2 3 4 5*	*Pain b/t shoulder blades*	*1 2 3 4 5*
Wheezing	*1 2 3 4 5*		
Neurological		***General***	
Headaches	*1 2 3 4 5*	*Fatigue*	*1 2 3 4 5*
Migraines	*1 2 3 4 5*	*Malaise*	*1 2 3 4 5*
Dizziness	*1 2 3 4 5*	*Weakness, tiredness*	*1 2 3 4 5*
Numbness	*1 2 3 4 5*	*Lightheadedness*	*1 2 3 4 5*
Tingling	*1 2 3 4 5*	*Irritability*	*1 2 3 4 5*
Pins/needles in hands or feet	*1 2 3 4 5*	*Constipation*	*1 2 3 4 5*
Diarrhea	*1 2 3 4 5*	*Chest Pain*	*1 2 3 4 5*
Feeling foggy	*1 2 3 4 5*	*Palpitations*	*1 2 3 4 5*
Forgetfulness	*1 2 3 4 5*		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian *Date*

Doctor's Review

_____ _____

Signature of Doctor *Date*

VANGUARD MEDICAL CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

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.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Permission to Use Photograph

I grant to Vanguard Spine & Sport, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorized Vanguard Spine & Sport, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Vanguard Spine & Sport may use such photographs of me with or without my name and for any lawful purpose, including for example such purpose as publicity, illustration, advertising, and web content.

I have read and understand the above:

Signature:_____

Printed Name:_____Date:_____

Signature, parent or guardian _____ (if the under age 18).

Vanguard Spine & Sport
8800 Katy Freeway Suite 105
Houston, TX 77024

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
The practice reserves the right to change the privacy policy as allowed by law.
The practice has the right to restrict the use of the information but the practice does not have to agree to those
restrictions.
The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or on your cell phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____(PRINT NAME PLEASE)

Signature: _____Date: _____
Witness: _____ Date: _____