Los Angeles Spinal Decompression ™

PLEASE PRINT CLEARLY:

Name:____ Birth date:_______________ Today's Date:_______________

Cell phone:___________________________ Home phone:___________________________SS#_______________________

Cell Provider (Circle one): Verizon T-mobile Sprint Cingular/AT&T MetroPCS Nextel Other:___________________

Pregnant? (Circle one): Yes No Social Security No.:____________________________________

Address:____________________________________ City:____________________ State:_______ Zip Code:___________

Occupation:_______________________

Email Address:_____________________________________

Do you or your spouse have health insurance?: Yes No Insurance Company:_______________________

ID # ____________________________ GROUP# _______________________________

How did you hear about us?(Circle one): Google Yelp Yahoo City search Yellow pages Friend Family Attorney

What is the purpose of your visit?:____

What are your areas of concern/complaint?:____

Have you had chiropractic care before?: Yes No When: __________________________________

Have you had any surgeries? Yes No If so, what type?:____

Do you have any pre-existing conditions?:____

Please list current medications: (Prescription, OTC, Vitamins, Herbs): ____

____

I give Drs, Karr, Ortiz, and Tsai, or this office my full consent and permission to give treatment on myself and my minors (listed below). Minors listed are either my own children or my legal adoptees, I authorize Drs, Karr, Ortiz, & Tsai, or this office to furnish complete information to my insurance carrier(s) and/or its (their) intermediaries and to submit a claim for all services rendered by this office. I authorize and direct my insurance carrier(s) and/or its (their) intermediaries to issue payment checks directly to this office for all services rendered. I understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered to me will be immediately due and payable in full. If it is ever necessary for this office to employ collection counsel and /or take collection measures, I waive all rights of confidentiality, and I understand that I am responsible for those collection charges in addition to the fees for professional services for unpaid date(s) of service, I give Drs, Karr, Ortiz, and Tsai, or this office my permission to release any x-rays taken of me to any radiologist, to release and forward any information in my chart(s) to that/those radiologist(s) necessary for the radiologist to bill myself and/or any insurance company, and I give that/those radiologist(s) permission to bill myself and/or any insurance company for their service.

Minor Name:_________________________________ Date of birth:________________ Relationship to Minor:______________

Signature:____ Date:_______________________