NEW PATIENT INFORMATION

REFERRED BY_____

NAME_____Age:_____Birthdate_____

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE #_____CELL#_____SS #_____

E-MAIL_____RELATIVE'S PHONE #:_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____WORK PHONE_____

CITY_____STATE_____ZIP_____

PRIMARY INSURANCE_____
INSURED'S NAME_____INSURED'S BIRTHDATE_____
INSURED'S ID #_____RELATIONSHIP _____
GROUP #_____INSURED'S EMPLOYER_____

INFORMED CONSENT FOR 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, on me (or on the patient named below, for whom I am legally responsible) by Dr. Wasserman. I will have the opportunity to discuss with Dr. Wasserman and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand 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 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, is in my best interest. I have read, or have had read to me, the above consent. I will have 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) or which I seek treatment here at this office.

I ALSO GIVE MY FULL AND COMPLETE PERMISSION FOR THIS MEDICAL GROUP TO TREAT MYSELF OR MY MINOR CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY, AND **ASSIGN ALL MY PAYMENTS DUE TO THE DOCTOR.** I HEREBY AUTHORIZE THE GROUP TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT REQUIRED FOR THE PURPOSE OF BILLING. A PHOTOCOPY OF THIS ASSIGNMENT WILL BE AS VALID AS THE ORIGINAL.

THIS COMPLAINT OF _____WAS **NOT** CAUSED BY AN AUTOMOBILE ACCIDENT, RELATED TO EMPLOYMENT, OR OCCUR ON COMMERCIAL PROPERTY.

SIGNATURE_____DATE_____

STEVEN B. WASSERMAN, R.N., D.C.
3772 KATELLA AVE., STE. 100 LOS ALAMITOS, CA 90720
tel (562) 430-4949 fax (562) 381-9777

Out-of-Network, and Non-Participating, and Out of State Policies; Provider Acknowledgement: Blue Cross, United Health Care, CIGNA, ASHP groups, ASN, ACN, OptumHealth, Etc..

Patient's Name:_____ Date:_____

I_____, understand that Dr. Wasserman is no longer a participating provider with my insurance company. Therefore, I will be responsible for all services rendered at time of service.

Dr. Wasserman's office may as a courtesy bill my insurance company (if applicable). I am aware that I may or may not receive a reimbursement check in the mail from my insurance company, depending on my insurance company's contract and benefits, for services provided by Dr. Wasserman. Our office will calculate an estimated amount due, taking into account usual insurance payments. Any overpayments of deductible or co-insurance will be reimbursed directly to you.

I understand that payment will be due at the time of services rendered.

I understand this is not a guarantee that my insurance will cover the services received by me and that all services may be subject to review by my insurance company. (Please consult your insurance company to verify eligibility and benefits.)

I fully understand and agree with the above terms above.

_____ _____

Patient's Signature Date

FEES

Initial consultation, exam, adjustment, and physical therapy: $175.00
Initial consultation and exam only: $125.00
Adjustment and physical therapy: $65.00
Adjustment/thermal pack: $45.00

Patient not seen in over 6 months from last visit date; consultation, re-exam, adjustment, with or without physical therapy: $100.00
Supplies: separate charge per item
Physical Therapy= electrical stimulation, manual traction, laser, ultrasound, thermal pack

STEVEN B. WASSERMAN, R.N., D.C. 3772 KATELLA AVE., STE. 100
LOS ALAMITOS, CA 90720 tel (562) 430-4949 fax (562) 381-9777

Initial Symptom History

Please state your primary complaint of why you are here today:_____
_____

What caused this and how long have you had it:_____
_____

Have you had this condition in the past?_____

Please put a check that applies to your present condition:

Frequency: ____rare ____occasional ____frequent ____constant

Symptoms: ____ pain ____stiffness ____spasms

Intensity: 0 (none)- 10 (severe) = _____neck _____mid _____low back _____extremity

Quality: ____sharp ____dull ____stabbing

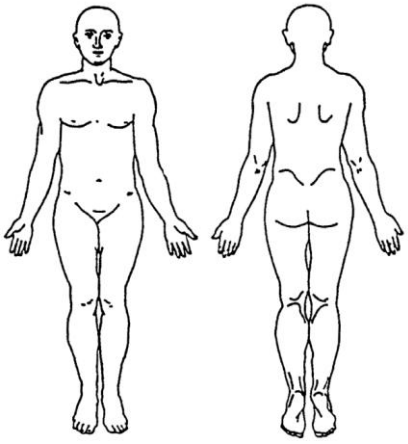
Assoc. Symptoms: ____weakness ____limited ranges of motion

radiating pain into_____ numb/tingling of_____

Aggravated by prolonged: ____sitting ____standing ____walking ____lying down ____driving

Relieved by: ____rest ____movement ____stretching ____Rx ____ice ____heat

Please mark the areas where your current complaints are located:



Signature_____**Date**_____

INITIAL HEALTH HISTORY

Allergies:_____

Medications/Supplements_____

Cholesterol Lowering Drugs:_____

Surgeries/Hospitalizations:_____

Pace Maker/Metal /Breast Implants_____

Cancer:_____
Diabetes:_____
Heart Disease:_____
Stomach/Colon:_____
Etc._____

Spinal Injuries/Accidents:_____

Previous Chiropractic Care: _____

Last Menstrual Period:_____ PREGNANT? ( ) YES ( ) NO

Previous MRI, CT Scans; X-Rays:_____

Exercise/Sports Activities:_____times per week: 1 2 3 4 5 6 7

Average Daily Emotional Stress Level: ( )very high ( )high ( )medium ( )minimal

Patient Signature_____Date_____

Comments: