Welcome to Changing Tides: Chiropractic & Wellness

Last Name First name M.I. Nickname

Address City State Zip Code

_____ _____ Cell Phone ( ) _____ - _____

Date of Birth Social Security No. Home Phone( ) _____ - _____

Email _____

Contact Preference: _____ Text _____ Call _____ Email

Your Occupation _____

Marital status: Married / Single / Divorced Spouse's Name _____

How were you referred to our office? _____

In case of an emergency who should be notified _____ Phone # _____

- I hereby give permission to the doctor to administer treatment and perform such general procedures she may deem necessary in the diagnosis and/or treatment of my condition.
- I understand it is my responsibility to inform this office of any changes in my medical status.

Authorization To Release Information

I authorized Changing Tides: Chiropractic & Wellness, LLC. to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to Changing Tides: Chiropractic & Wellness for the demand by Changing Tides: Chiropractic & Wellness, I hereby assign to transfer to Changing Tides: Chiropractic & Wellness the cause of action that exists in mu favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. **I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due). I personally owe you, and agree to pay in a current manner.**

Authorization to Pay Directly to Doctor

In consideration of the chiropractic services rendered and to be rendered by them, I authorize and direct the payment to Changing Tides: Chiropractic & Wellness any sum I now or hereafter owe them by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges of their services or otherwise obligated to make payment to me or Changing Tides Chiropractic & Wellness based in whole or in part upon the charges made for their services. I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of unpaid benefits claimed by CHANGING TIDES: CHIROPRACTIC & WELLNESS is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby IRREVOCABLY ASSIGN to CHANGING TIDES: CHIROPRACTIC & WELLNESS the right and benefits and any and all causes of action resulting from non-payment, under payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by CHANGING TIDES: CHIROPRACTIC & WELLNESS.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services from Eliana Melendez, D.C. and that I have been advised that the doctor providing services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either:

a) that there is no insurance company obligated to pay for services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor, or

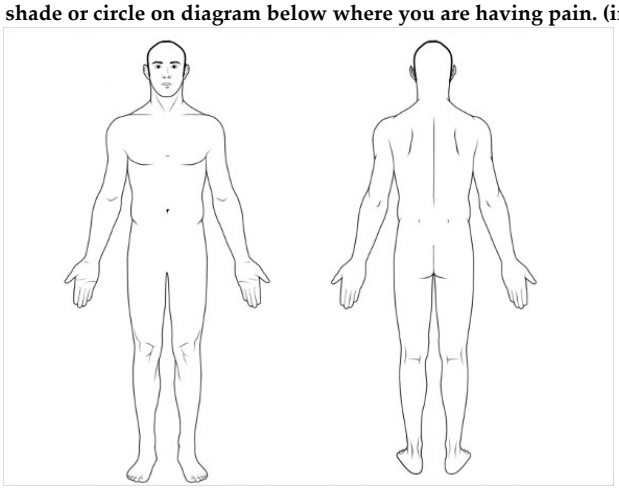
b) if a liability claim exits, and my attorney refuses to agree to protect interest of the doctor, or if I have not engaged the services of an attorney; then payments for services rendered by CHANGING TIDES: CHIROPRACTIC & WELLNESS will be made on a current basis and my bill paid in full as soon as any liability claim is settle or the passage of three months from my last treatment whichever occurs first.

c) I agree to pay any and all attorney and collection fees that are incurred by Changing Tides: Chiropractic & Wellness to collect past dues balances for services rendered to me by Changing Tides: Chiropractic & Wellness

Signature: _____ Date: _____

Last Name First Name M.I. Age

Please shade or circle on diagram below where you are having pain. (in any)



Please describe reason for visit:

_____

_____

Please indicate current level of pain: 1 2 3 4 5 6 7 8 9 10

Please describe your quality of pain (circle all that apply):

Sharp	Shooting	Stabbing	Constant	Aching	Tingling	Numbness
Intermittent	Dull	Throbbing	Burning	Occasional	Cramping	Stiffness

Prior treatment for present condition (Doctor's name(s) & dates): _____

Prior studies (Please circle): X-rays / MRI / CT scan / Other: _____

Please circle the symptoms you now you have or have had recently:

Headaches	Shortness of breath	Deafness	Painful urination
(Where) _____	Chest pain	Hoarseness	Excessive thirst
Fainting	Fatigue	Weight gain	Discolored urine
Loss of balance	Rapid heart beat	Weight loss	Problems voiding
Weakness	Excessive sweating	Abdominal pain	Menstrual problems
Slurred speech	Palpitation	Constipation	Alterations of:
Blurred vision	Poor circulation	Diarrhea	skin temperatures
Double vision	Swollen joints	Belching / gas	skin color
Ringing in ears	Wheezing	Stool changes	Enlarged glands
Nausea / vomiting	Cough / Phlegm	Rectal bleeding	Loss memory
Numbness	Cough / Blood	Fever	
(Where) _____	Eye pain	Incontinence	

*Patient Signature:*_____ *Date:*_____

Patient History, Continuation

Please circle the following conditions that you have had:

CVA / Stroke	Heart murmur	High blood pressure	Heart Disease
Mental disorder	Colitis	Scoliosis	Diverticulitis
Paralysis	Cirrhosis / Hepatitis	Hernia	Rheumatic fever
Tremors	Venereal disease	Psoriasis	Breast augmentation
Epilepsy	Alcoholism	Arthritis Type:	or reduction
Thyroid problems	Drug addiction	_____	Date _____
Kidney stones	Diabetes	Lung Disease	Allergies Type:
Cancer Type: _____	AIDS / HIV	Gall bladder disease	_____
	Polio	Anemia	

1. Please list any other serious medical condition you have or have ever had:

_____

_____

2. Fractures? No / Yes (area + date)

_____

3. Surgery? No / Yes (area + date)

_____

4. Car accidents? No /Yes (date)

_____

5. Serious accidents? No / Yes (describe + date)

_____

6. Hospitalizations? No /Yes (reason + date)

_____

7. Are you presently being treated for any other conditions? No / Yes;

If yes, by whom _____ For? _____

Who is your Primary Care Physician? _____

Family history: Please list any conditions / diseases that the following family members have had.

Mother: _____

Father: _____

Siblings: _____

Please tell us how much of the following you consume or do per day:

Tobacco _____ packs / day Alcohol _____ drinks / day Coffee _____ cups / day

Sleep _____ hours / day Exercise _____ hours / week Appetite _____ meals / day

Vitamins / Supplements: _____

Drugs / Medications: _____

Sport / Activities: _____

*Patient Signature:*_____ *Date:*_____