Date _____ Pt. No. _____ Name _____

Address _____ Insurance _____

Telephone No.: _____ Referred By: _____ Occupation: _____ Age ____ Sex ____ S.M.W.D

Chief Complaint _____

How Did It Happen?: _____ Duration: _____

Type of Pain: _____ Radiation: _____

Any Similar Condition: _____ Disability Began: _____ Interfere With Work _____

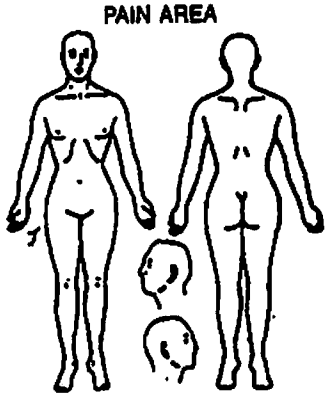
Pain Increased When: _____ Date of Last Physical: _____

Any Previous Treatment: _____

Evaluation of Chief Complaint: _____

History and Present Illness: _____

PAIN AREA



PATIENT SEATED

Spine	Tender	Muscle Sp:	Palp. Sub:
Cervical			
Thoracic			
Lumbar			
Sacrum			
Pelvis			

BP R ____ L ____ George's ____ Depress ____

FCT R ____ C ____ L ____ Distract ____ Del Triad ____

Bechterew ____ Grip R ____ L ____ Pat (L4) ____

Bi (C5) ____ Tri (C7) ____ Brach (C6) ____

PATIENT STANDING:

Kemp R ____ L ____ Posture ____

Walk H ____ T ____ Antalgic ____

Gait ____ Bil. Wt. ____

Cervical Motion		Nor	Rest	Pain
Flexion		45		
Extension		55		
Rotation	(R)	70		
Rotation	(L)	70		
Lateral	(R)	40		
Lateral	(L)	40		

Dor-Lum Motion		Nor	Rest	Pain
Flexion		80		
Extension		30		
Rotation	(R)	35		
Rotation	(L)	35		
Lateral	(R)	30		
Lateral	(L)	30		

PATIENT SUPINE: S.L.R. _____ Lasegue _____ Soto Hall _____ Fab. Pat. _____

Gaenslen's _____ Braggard _____ Bowstring _____ Linders _____ W.L.R. _____

PATIENT PRONE: Ach. (S1) _____ Ely's _____ Nachlas _____

Yeomans _____ Moses _____ Hibbs _____

PERIPHERAL SENSITIVITY (U.E.) R _____ L _____ (L.E.) R _____ L _____

MOTOR CHANGES (U.E.) R _____ L _____ (L.E.) R _____ L _____

DC DIAG: _____

Prognosis: _____

PT. MANAGEMENT: Inst. _____ C Hist: _____ Tapes _____ _____ ORX _____ Lect _____

ADDITIONAL NOTES: _____

X-RAY EXAMINATIONS: Analysis: C _____ T _____ L _____ P _____

Pathology: _____

NOTES:

Craig A. Sainz, D.C., P.A.

Patient No._____ Date:_____

Patient Personal/Confidential Data

Name_____ Date of Birth_____
Home Address_____ City_____ Zip_____
Home #_____ Work #_____ Cell #_____
Email_____ ☐Male ☐Female ☐Single ☐Married ☐ Other
SSN_____ Referred by _____

Employment Status ☐Full-Time ☐Part-Time ☐ Full- Time Student ☐Part-Time Student
Employer/School_____ Occupation_____
Address_____ City_____ Zip_____

Name of Spouse_____ SSN_____ No. Of Children_____
Spouse's Employer_____ Address_____
Nearest relative not living with you?_____ Phone_____
Who is responsible for payment? ☐Self ☐Spouse ☐Other_____

Patient's Insurance
Company_____
Address_____
ID No._____
Group No._____
Phone No._____

Spouse's Insurance
Company_____
Address_____
ID No._____
Group No._____
Phone No._____

Purpose of this appointment and list your complaints_____
_____
Date of Illness_____ Time_____ AM/PM Location_____
How did accident occur? ☐ Auto ☐ On the Job ☐Other_____
Please describe the circumstances and what makes the condition(s) better or worse:_____
_____
_____
_____
_____

Other Doctor(s) seen for this condition:_____
Have you been treated by a Doctor for any health conditions in the last year? ☐ Yes ☐No
If yes, Please describe:_____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date:_____

Patient:_____ No.:_____

MUSCULOSKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITOURINARY SYSTEM

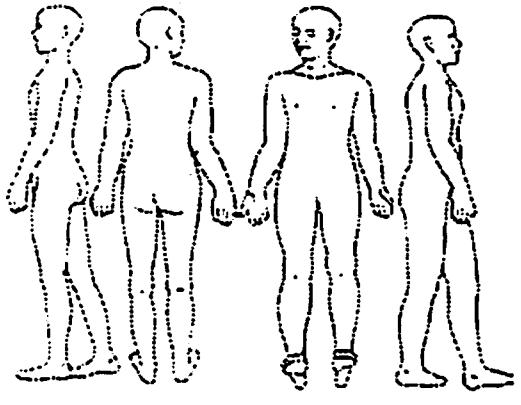
- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?
☐ YES ☐ NO

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypesthesia

Pain Index
Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTROINTESTINAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Exercise
- ☐ Drug Abuse
- ☐ _____

CARDIOVASCULAR SYSTEM

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficulty breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

Patient's Signature_____

•••••••••••••••••••• DO NOT WRITE BELOW THIS LINE ••••••••••••••••••••

Patient Accepted? ☐ Yes ☐ No Doctor's Signature_____

Craig A. Sainz, D.C., P.A.

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.

Craig A. Sainz, D.C., P.A.

Office Financial Policy

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services are due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. We accept cash, checks, debit* and credit cards*. Returned checks and balances older than 30 days may be subject to additional collection fees, including but not limited to court costs, interest and reasonable attorney's fees. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.
*service fees may apply

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing or insurance claims is a courtesy that we extend to your patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us. We are here to help you.

Patient's Signature:_____ Witness:_____

4631 NW 53rd Ave, Suite 106
Gainesville, FL 32606
(Bristol Park)
352-378-8500

Craig A. Sainz, D.C., P.A.

Authorizations and Releases

Consent For Treatment:

I, the undersigned, hereby authorize Craig A. Sainz, D.C., P.A. and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Patient's Signature: _____ Date:___/___/___ Witness: _____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature: _____ Date:___/___/___ Witness: _____

Request for Payment of Benefits to Provider of Care

I herby authorize the _____ Insurance Company/Insurance administrator to pay by check and for it to be mailed directly to: Craig A. Sainz, D.C., P.A 4631 NW 53rd Ave Suite 106 Gainesville, FL 32606 the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature: _____ Date:___/___/___ Witness: _____

Attorney Representation and Protection of balance

I, the undersigned patient am directing my Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I herby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent or any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's Signature: _____ Date:___/___/___ Witness: _____

Consent for Treatment for Minor

I herby authorize Craig A. Sainz, D.C., P.A and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child)_____ (child's name) _____.

Guardian's Signature: _____ Date:___/___/___ Witness: _____

X-Ray/Medical Records Release

I have requested the release of records of (patient's name) which are a part of the records at (facility) _____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies or records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to: (name)_____ (address)_____

Patient's signature: _____ Date:___/___/___ Witness: _____