BURLEIGH HEALTH CENTER & REHAB
9740 BARKER CYPRESS ROAD, SUITE 111, CYPRESS, TEXAS 77433

TEL: 832-237-3331
FAX: 832-237-4638

NEW PATIENT INFORMATION

Please Print all Answers

Date: _____ / _____ / 2019

Name _____ Age _____ Sex _____ Birth Date _____

Address _____

Home Phone _____ Work _____ Cell _____

Email: _____ Race: _____ Ethnicity: _____

Do we have permission to send electronic reminders to you with your upcoming appointments? ☐ Yes ☐ No

Please mark your Cell Service: ☐ AT&T ☐ Nextel ☐ Sprint ☐ T-Mobile ☐ Metro ☐ Boost ☐ Aerial ☐ Other: _____

Social Security # (REQUIRED) _____ Number of Children _____

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse Name _____

Employer _____ Employer Phone _____

Employer Address _____ City, State, Zip _____

Emergency: Who Do We Call? _____ Phone _____ Relationship _____

REFERRAL INFORMATION

Who recommended you to our office? ☐ My Doctor ☐ Family / Friend ☐ Other _____

Name _____ Telephone # _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birth Date _____ Relationship _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birth Date Relationship

REASON FOR VISIT

What is your chief problem or symptoms? _____

What caused the problem or symptoms to occur? _____

When did the problem or symptoms begin? _____

Have you seen another doctor for this problem? ☐ No, If yes, who _____

What tests/procedures have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization ☐ Transplant

Have you had this problem or symptoms in the past? ☐ No, If yes, explain _____

Have you tried any other treatments for this? ☐ No, If yes, explain _____

DRIVERS LICENSE & INSURANCE CARD
TO BE PHOTOCOPIED FOR YOUR PERMANENT MEDICAL RECORD

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PATIENT & FAMILY HISTORY

EMPLOYMENT STATUS

What is your occupation? _____ ☐ Full Time ☐ Part Time

What is your employment status? ☐ Working ☐ Unemployed ☐ Retired ☐ Disabled

TOBACCO USE

Do you use tobacco?

Type: ☐Cigarette ☐Cigar/Pipe ☐Chew ☐Dip

☐ Current Every Day
☐ Former Smoker
☐ Never

Number of years smoking? _____
Number of years quit? _____
What year did you quit? _____

SUBSTANCE USE

Do you have a history of substance abuse? ☐ No ☐Yes Explain: _____

Do you consume alcohol? ☐ None ☐Rarely ☐Social ☐ Recovering

Do you Exercise? ☐ No ☐Yes Frequency: ☐ None ☐Occasional ☐Frequent ☐Regular

Do you drink caffeine? ☐ No ☐Yes Frequency: ☐ Denies ☐Frequently ☐ Rarely

ACCIDENTS

Severe accidents or trauma & dates _____

SURGERIES

Have you had any surgeries? ☐ No ☐Yes _____

ALLERGIES

List all drug / chemical / latex / iodine allergies _____

MEDICATION

List all current medications / drugs

Drug Name: ☐ *See Attached Copy* _____ _____

_____ _____

_____ _____

FEMALES ONLY: Are you pregnant? ☐ No ☐Yes Last Menstrual Cycle Date: _____

List all physicians you have seen in the past 5 years?

Name _____ For What? _____

_____ _____

FAMILY HISTORY

PLEASE LIST MEDICAL ISSUES:
Cancer, Heart Trouble, Diabetes, etc...

Father	☐ Living	Age: _____	☐ Deceased – Cause of Death	_____
Mother	☐ Living	Age: _____	☐ Deceased – Cause of Death	_____
Brother(s)	☐ Living	Age: _____	☐ Deceased – Cause of Death	_____
Sister(s)	☐ Living	Age: _____	☐ Deceased – Cause of Death	_____

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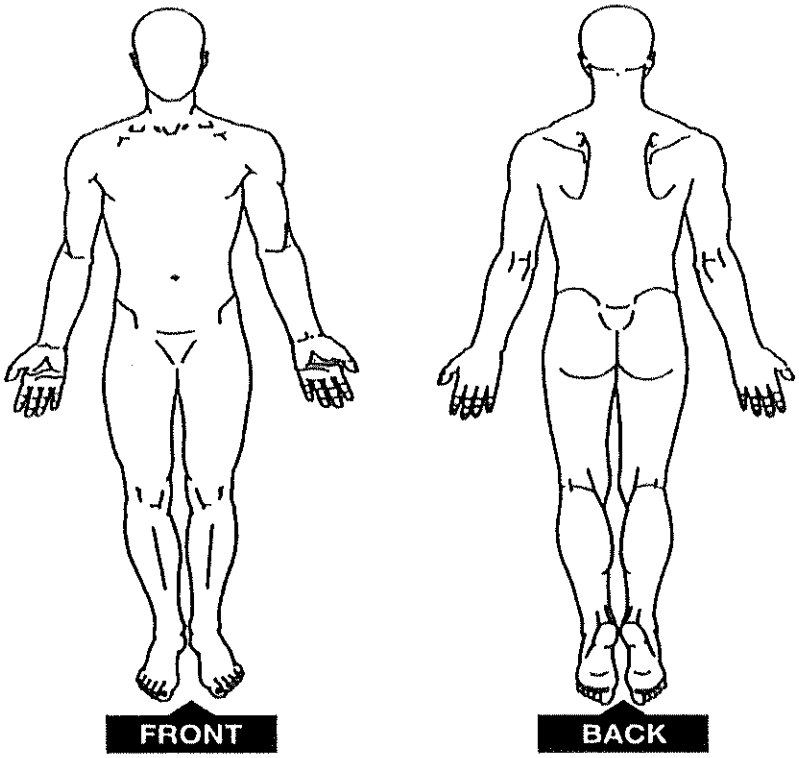
Using the picture below, shade the area where you feel your pain.



_____
_____
_____
_____

Describe your pain (check all that apply):

- ▯ Deep Ache
- ▯ Duli Ache
- ▯ Sharp
- ▯ Shooting
- ▯ Sharp/Stabbing w Motion
- ▯ Throbbing
- ▯ Vague Discomfort

How **Often** do you have your pain?

- ▯ Constant
- ▯ Frequent
- ▯ Occasional
- ▯ Intermittent

On a scale of 1 to 10 how would you rate your pain level? _____
(1=Minimal, 10=Excruciating)

What do you do to help decrease or control your symptoms?

_____
_____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

Auto Accident	Date: _____	Time: _____ ☐AM ☐PM
	▯ Driver	▯ Passenger
	▯ Unconscious	▯ Treated in E.R.
	▯ Wearing a Seat Belt	▯ YES ▯ NO
	▯ Transported by Ambulance	▯ YES ▯ NO
Vehicle Damage	▯ Minimal - Moderate	▯ Severe - Totaled
	Was the vehicle towed away?	▯ YES ▯ NO
Police Report	▯ None	▯ YES with Police Dept. _____
Hospital	▯ YES ▯ NO	Hospital Name: _____

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PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Select ALL symptoms that you have had in the past as well as those that you presently have

	PAST	PRESENT
Constitutional		
Chills	☐	☐
Fatigue	☐	☐
High Fever	☐	☐
Night Sweats	☐	☐
Weight Change	☐	☐
Eyes		
Blindness	☐	☐
Blurred Vision	☐	☐
Cataracts	☐	☐
Pain	☐	☐
Watery	☐	☐
ENMT *Ears*		
Ear Aches	☐	☐
Hearing Loss	☐	☐
Tinnitus	☐	☐
Vertigo	☐	☐
Nose		
Congestion	☐	☐
Discharge	☐	☐
Rhinitis	☐	☐
Sinus Pain	☐	☐
Mouth		
Bleeding Gums	☐	☐
Dental Pain	☐	☐
Dry Mouth	☐	☐
Taste Abnormality	☐	☐
Throat		
Laryngitis	☐	☐
Lump in Throat	☐	☐
Sore Throat	☐	☐
Voice Changes	☐	☐
Chest/Breast		
Discharge	☐	☐
Mass	☐	☐
Nipple Abnormality	☐	☐
Pain	☐	☐
Respiratory		
Asthma	☐	☐
Cough	☐	☐
COPD	☐	☐
Interstitial Lung Disease	☐	☐
Pulmonary Fibrosis	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

	PAST	PRESENT
Cardiovascular		
Chest Pain	☐	☐
Heart Attack	☐	☐
Hypertension	☐	☐
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heart Beat	☐	☐
Stroke	☐	☐
Gastrointestinal		
Abdominal Pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
GERD	☐	☐
Nausea	☐	☐
Ulcers	☐	☐
Genitourinary		
Erectile Dysfunction	☐	☐
Hematuria (Blood in Urine)	☐	☐
Kidney Stones	☐	☐
Prostate Enlarged	☐	☐
STD	☐	☐
UTI Symptoms	☐	☐
Integumentary		
Bruising	☐	☐
Color Change	☐	☐
Dry Skin	☐	☐
Itching	☐	☐
New or Changing Moles	☐	☐
Rash	☐	☐
Musculoskeletal		
Limitation of Movement	☐	☐
Extremity Pain	☐	☐
Spine Pain	☐	☐
Trauma or Recent Injury	☐	☐
Neuro *Autonominc*		
Cyanosis (Blue skin)	☐	☐
Erythema (Red skin)	☐	☐
Pallor (White skin)	☐	☐
Cranial Nerves		
Equilibrium Distrubance	☐	☐
Facial Weakness	☐	☐
Hearing Disturbance	☐	☐
Smell Disturbance	☐	☐
Speech, Swallowing Disturbance	☐	☐
Visual Disturbance	☐	☐

	PAST	PRESENT
Neuro *Head*		
Blackout	☐	☐
Headache	☐	☐
Memory Loss	☐	☐
Vertigo	☐	☐
Motor		
Convulsions/Seizures	☐	☐
Involuntary Motion	☐	☐
Muscle Atrophy	☐	☐
Paralysis	☐	☐
Sensory		
Decreased Sensation	☐	☐
Numbness	☐	☐
Tingling	☐	☐
Sensation Loss	☐	☐
Psyche		
Anxiety Problems	☐	☐
Bipolar	☐	☐
Dementia	☐	☐
Depression	☐	☐
Hallucinations	☐	☐
Endocrine		
Diabetes	☐	☐
Excessive Sweating	☐	☐
Excessive Thirst/Hunger	☐	☐
Heat or Cold Intolerance	☐	☐
Obesity	☐	☐
Thyroid Disease	☐	☐
Hematic/Lymph		
Anemia	☐	☐
Clotting Problems	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
Allergies		
Allergy	☐	☐
Conjunctivitis	☐	☐
Hay Fever	☐	☐
Other		
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

PLEASE FAX RECORDS TO (832) 237-4638

BURLEIGH HEALTH CENTER & REHAB, PLLC
BURLEIGH CHIROPRACTIC CENTER PC
Tel: (832) 237-3331
Fax: (832) 237-4638

MEDICAL RECORDS REQUEST FORM

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC may verify your identity/guardianship. Some requests may be subject to a reasonable fee. Please print.

PART 1: PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP: _____

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS. I AUTHORIZE THE FOLLOWING TO DISCLOSE TO BURLEIGH HEALTH CENTER & REHAB, PLLC AND/OR BURLEIGH CHIROPRACTIC CENTER, PC FOR THE PURPOSE OF CONTINUING MEDICAL CARE AND/OR MEDICAL TREATMENT.

CLINIC: _____ PROVIDER NAME: _____

TEL/FAX: _____ DATE(S) OF SERVICE: _____

INFORMATION TO RELEASE:

- ☐ All Health Information
- ☐ History / Physical Exam
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Lab Results
- ☐ Pathology Reports
- ☐ Radiology Reports and/or Images
- ☐ EKG/Cardiology Reports
- ☐ Operative Reports
- ☐ ER Records
- ☐ Other
- ☐ Date of Service: _____

DISCLOSURE OF SENSITIVE INFORMATION

You have the right to refuse disclosure and prevent any other person from disclosing sensitive information related to the following conditions, treatments, or testing. To exclude this information from disclosure, check the appropriate checkbox(es). To EXCLUDE this information with disclosure, check the last checkbox in the list*

- ☐ Psychological/Psychiatric Condition
- ☐ Drug and/or alcohol abuse diagnosis and/or treatment
- ☐ HIV AIDS diagnosis and/or treatment
- ☐ Genetic Testing
- ☐ I authorize the disclosure of **ALL** sensitive information
- ☐ I DO NOT authorize the disclosure of **ANY** sensitive information*

TO BE COMPLETED ONLY FOR THIRD-PARTY DISCLOSURES. (DISCLOSURE IS FOR PERSONAL USE, SKIP THIS SECTION)

I want the requested medical records to be sent to the third-party (for example, an employer or a school) I have indicated below. My completion of this form serves as authorization for Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC to disclose these records to this person or group. I understand that once my information leaves Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC, Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

NAME: _____ TELEPHONE: _____

ADDRESS: _____ CITY / STATE / ZIP: _____

TERMS OF AUTHORIZATION

I understand this authorization may be revoked in writing at any time, according to the instructions in Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated: _____. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes. Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC will not condition treatment or payment on my completion of this form.

X Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance, and mental health treatment (Texas Family Code 32.003).

Minor's Signature: _____ Date: _____

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

Welcome to our multi-specialty group practice. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests, x-rays &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

AUTHORIZATION FOR TREATMENT, USE OF TESTING & X-RAY DIAGNOSTIC PROCEDURES: I the undersigned patient in this office, hereby authorize Burleigh Health Center & Burleigh Chiropractic Center, P.C. to administer such evaluation and treatment as necessary and perform therapy and manipulation as are considered therapeutically necessary on the basis of findings during the course of said treatment. I further consent to the use of X-Ray diagnostic procedures and release Burleigh Health Center & Burleigh Chiropractic Center, P.C. from any liability resulting from the use of said X-Ray procedures. I hereby certify that I have fully read and fully understand the above Authorization for Treatment and Use of X-Ray Diagnostic Procedures, the reasons why the treatment and procedures are considered necessary and the advantages and possible complications, if any as well as possible alternative modes. Treatments, which were explained to me by Burleigh Health Center, I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. If you must miss an appointment please notify us. We are available to immediately see new patients the same day or through our 24 hour - 7-day emergency service. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

X

Signature (if minor, parent must sign)

Date