

**Dr. Erick A. Daes, D.C., P.A.**  
8955 S.W. 87<sup>th</sup> Court  
Miami, Florida 33176  
305-233-5700 305-279-2222

## PATIENT INFORMATION

**(IF THIS IS RELATED TO AN AUTO ACCIDENT OR WORK INJURY PLEASE TELL THE FRONT DESK.)**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL \_\_\_\_\_

**Please print clearly email address.**{Your email will not be shared with 3<sup>rd</sup> parties. It will be used to communicate with you from our office and to send periodic reminders, newsletters and information of interest}

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ STATUS---M S W D

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK TELEPHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SPOUSE'S EMPLOYER & PHONE \_\_\_\_\_

NAMES & AGES OF CHILDREN \_\_\_\_\_

NAME AND PHONE OF EMERGENCY CONTACT \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

PRIMARY DOCTORS NAME: \_\_\_\_\_

## **INSURANCE INFORMATION**

NAME OF COMPANY \_\_\_\_\_

INSURED NAME AND DATE OF BIRTH \_\_\_\_\_

GROUP # \_\_\_\_\_ IDENTIFICATION # \_\_\_\_\_

**\* PLEASE REMEMBER TO GIVE THE FRONT DESK A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE**

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**PATIENT HISTORY FORM**

**Patient's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**REASON(S) FOR VISIT**

**Please circle all that apply:** Work, Sport, Auto Accident, Spinal Pain, Spinal Curvature correction (including Scoliosis), Headaches, Arm and/or Leg pain/sciatica, Back Pain, Muscle Spasms, Preventive Checkup/Care, Misaligned Vertebrae, "Slipped disc" [bulge or herniation], Loss of Strength or feeling in the arm/hand or thigh/leg.

**When did the condition begin?** \_\_\_\_\_

**Explain what happened** \_\_\_\_\_

**How often do you experience your symptoms?** Please check one:

Constantly \_\_\_\_\_ (76-100% of the day) Frequently \_\_\_\_\_ (51-75% of the day)

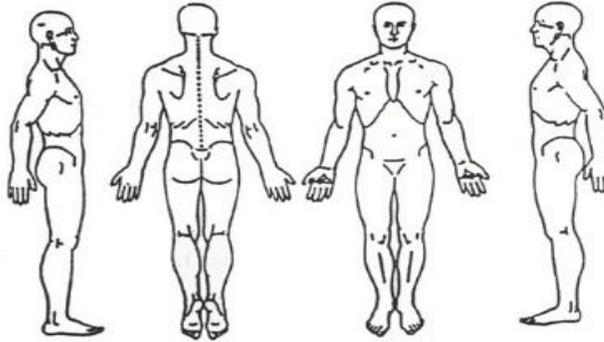
Occasionally \_\_\_\_\_ (26-50% of the day) Intermittently \_\_\_\_\_ (0-25% of the day)

**What describes the nature of your symptoms?**

Sharp \_\_\_\_\_ Shooting \_\_\_\_\_ Dull Ache \_\_\_\_\_ Burning \_\_\_\_\_ Numb \_\_\_\_\_ Tingling \_\_\_\_\_

**Mark the appropriate symbol on the picture where you are having pain.**

Aching \*\*\*\*\* Stabbing ////////////// Numbness ----- Burning XXXXXXX Pins and Needles 000000



**Indicate the average intensity of your symptoms:** (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

How are your symptoms getting? Better \_\_\_\_\_ Worse \_\_\_\_\_ Not Changing \_\_\_\_\_

Has it interfered with your: Work \_\_\_\_\_ Sleep \_\_\_\_\_ Daily Routine \_\_\_\_\_ Recreation \_\_\_\_\_

Have you ever been treated by a medical physician for this condition? YES \_\_\_ NO \_\_\_

Have you ever been treated by a chiropractor? YES \_\_\_ NO \_\_\_

List all medical conditions: \_\_\_\_\_

List medications/birth control: \_\_\_\_\_

List major surgeries: \_\_\_\_\_

Do you have any allergies/asthma? YES \_\_\_ NO \_\_\_ If so, please list: \_\_\_\_\_

If female, are you pregnant? YES \_\_\_ NO \_\_\_ Date of last menstruation \_\_\_\_\_

Do you smoke? YES \_\_\_ NO \_\_\_ How much \_\_\_\_\_

Do you use other substances? YES \_\_\_ NO \_\_\_

Do you consume alcohol? Never \_\_\_\_\_ Rarely \_\_\_\_\_ Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_

**Signature** \_\_\_\_\_

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## Medical History

Please Check and Describe Below any of the following you have had in the last 12 months and/or ever received treatment for:

**MUSCULO-SKELETAL Describe Checked Item:**

Low Back Pain                       Pain Between Shoulders                       Neck Pain  
 Joint Pain/Stiffness                       Walking Problems                       Arm Pain  
 General Stiffness                       Difficult Chewing/Clicking Jaw

**GENITO-URINARY**

Painful/Excessive Urination                       Discolored Urine                       Bladder Trouble

**CARDIO-VASCULAR-RESPIRATORY**

Chest Pain                       Short Breath                       Blood Pressure Problems  
 Irregular Heartbeat                       Heart Problems                       Lung Problems/Congestion  
 Varicose Veins                       Ankle Swelling                       Stroke

**NERVOUS SYSTEM**

Nervous                       Numbness                       Paralysis                       Dizziness  
 Forgetfulness                       Confusion/Depression                       Fainting                       Convulsions  
 Cold/Tingling Extremities                       Stress                       Hearing Difficulty

**EYES, EARS, NOSE, THROAT**

Vision Problems                       Dental Problems                       Sore Throat  
 Ear Aches                       Stuffed Nose

**GENERAL**

Fatigues     Allergies     Headaches     Fever

**MALE/FEMALE**

Menstrual Irregularity                       Menstrual Cramps                       Vaginal Pain/Infection  
 Breast Pain/Lumps                       Prostate/Sexual Dysfunction                       Other: \_\_\_\_\_

**GASTRO-INTESTINAL**

Poor/Excessive Appetite                       Excessive Thirst                       Frequent Nausea  
 Vomiting                       Diarrhea                       Constipation  
 Hemorrhoids                       Liver Problems                       Gall Bladder Problems  
 Weight Trouble                       Abdominal Cramps                       Gas/Bloating after meals  
 Heartburn                       Black/Bloody Stools                       Colitis

**DESCRIBE ABOVE CHECKED ITEMS:**

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT NAME: \_\_\_\_\_  
PATIENT SIGNATURE: \_\_\_\_\_

Doctor Initials: \_\_\_\_\_  
Date: \_\_\_\_\_

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## **Patient Consent for Use of Disclosure of Protected Health Information**

I give my consent for the above Doctor to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO)

Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The above stated Doctor reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Private Practices may be obtained by forwarding a written request to the above stated Doctor.

With this consent, the above stated Doctor may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the above Doctor may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as they are marked Personal and Confidential.

With this consent, the above stated Doctor may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the above stated Doctor use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the above stated Doctor may decline to provide treatment to me.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Print name of Patient or Legal Guardian**

\_\_\_\_\_  
**Date**

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I understand the information on all forms and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes in my medical status.

I authorize the staff to perform any necessary services during the diagnosis and treatment. I also authorize the provider and/or managed care organizer to release any information required to process insurance claims.

I authorize Dr. Erick A. Daes to provide medical services to me.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collection your account. I understand that I am financially responsible for all changes whether or not paid by the insurance companies.

I authorize the release of any medical information necessary to process this claim including but not limited to all of my insurance companies. I also request payment of government benefit either to myself or to the party who accepts assignments below.

**Signature on File:**

I authorize payment of medical benefits to the undersigned physician(s) or supplier of service. I authorize physician to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my physician. I permit a copy of this authorization to be used in place of my original signature. I authorize use of this form on all my insurance submissions.

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**Patient's Signature**

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**Date**

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**Doctor's Signature**

---

**Date**

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## **INFORMED CONSENT TO TREAT**

(Patient: Please discuss any questions or concerns with the Doctor before signing this consent.)

I hereby request and consent to the performance of manipulation (adjustments) and other procedures including diagnostic x-rays and various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible.)

I have had the opportunity to discuss with the doctor and/or with other office or clinical personnel the purpose and benefits of Manipulations (adjustments) and other treatments outlined below. Alternatives to treatments have been reviewed.

I understand that I will be receiving one or more of the following treatments: Manipulations (adjustments), Mobilization Therapy, Hot/Cold Packs, Electrical Stimulation, Inferential Current, Myofascial Release, Traction, Therapeutic Exercises, Massage, Spinal Decompression, Mechanical Traction, Passive Mobilization, Taping or Splinting.

I understand that Manipulation (adjustments) is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding treatment that I have requested or authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

\_\_\_\_\_  
**Signature of Patient (or guardian)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Doctors Signature**

\_\_\_\_\_  
**Date**