PATIENT INFORMATION

( ) Cash ( ) Health Insurance ( )Personal Injury ( ) Other

PATIENT NAME: _____ DOB: ___/___/____ Age: _____

ADDRESS: _____ **MALE / FEMALE**
Street Apt #

_____
City State Zip Code

Cell: ( ) _____ H Phone: ( ) _____ Email: _____
Best reached by EMAIL / PHONE / TEXT

DRIVER'S LICENSE #: _____ SOCIAL SECURITY #: _____ - _____ - _____

MARITAL STATUS: Single Married Divorced/Separated Widowed
Spouse's Name: _____

Work Status: EMPLOYED RETIRED DISABLED F/TIME STUDENT P/TIME STUDENT
Employer: _____ Occupation: _____ How long? _____
Employer Address: _____
_____ Work phone: ( ) _____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? _____
Relation: _____ Phone: ( ) _____ Other: _____

PRIMARY HEALTH INSURANCE INFORMATION **PPO / HMO / EPO / OTHER**
Company Name: _____ ID#: _____
Address: _____ Phone#: _____
Insured's Name: _____ Relation: _____ DOB: _____
Insured's SSN: _____ -_____-_____ Insured's Employer: _____

Secondary/Spouse's Health Information: _____
_____

Ever been treated by a chiropractor before? **YES/NO** Date: ___/___/_____
Referred by: _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due. _____

MINORS - CONSENT FOR TREATMENT

I hereby authorize the staff at Optimum Care Therapy to administer Chiropractic and/or Physical Therapy care as they deem necessary to my son/daughter, _____.

_____
Parent/Legal Guardian Name Signature Date

_____
Print Name Signature Today's Date

Name: _____ Date: _____

Please describe the reason for this visit:

_____
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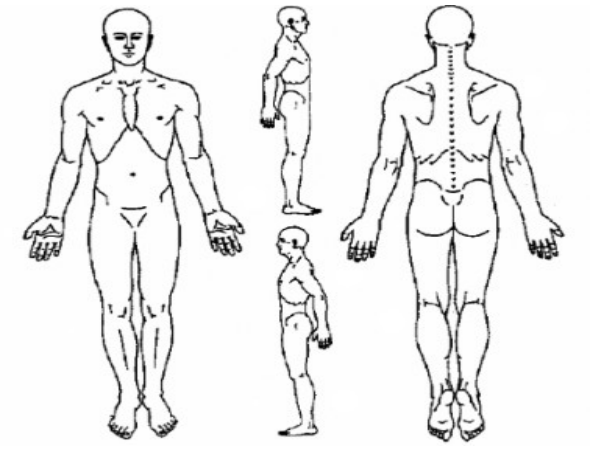

Mark which sensation is most appropriate on diagram:

XXX	Sharp, stabbing pain
OOO	Shooting pain
NNN	Numbness, tingling
SSS	Sore, dull, achy

(Please use back of page if more room is needed)

How long have you had these symptoms? _____
Is this condition getting BETTER WORSE NO CHANGE
Please check any that apply: ___ PINS/NEEDLES ___ TINGLING ___ NUMBNESS ___ OTHER
Have you seen any other doctors for this condition? YES/NO
(If so, please include doctor, dates, diagnosis, treatment received and any residuals you still suffer from)

_____
_____

Date of last physical: _____/_____/_____ Date of last menstrual cycle: _____/_____/_____
Do you believe you may be pregnant? YES/NO
Do you have any infectious disease? YES/NO If yes, please identify _____

Have you had any surgeries? YES/NO
Describe and date: _____
_____

Have you recently been hospitalized for any reason? YES/NO
Describe and date: _____
_____

Have you been involved in any recent accidents or trauma? YES/NO
Describe and date: _____
_____

Please list all conditions/medications for which you are being treated by other physicians:

Medication/Reason:	Dosage:	Duration:

INFORMED CONSENT / PATIENT INFO FOR CHIROPRACTIC TREATMENT

I, the undersigned, as a patient of Optimum Care Therapy Chiropractic & Dr. Senkosal Uy, understand that the form of care is based on Chiropractic principles and practices. I request and consent to the performance of chiropractic adjustments which include, but are not limited to, physiotherapy, other forms of manual therapy, laser therapy, and infrared/thermotherapy.

I will inform my chiropractic doctor of all my health concerns, allergies, medications, supplements and medical interventions because safe care requires that I truthfully and completely disclose this information. I will inform my chiropractor if I am (or have the possibility of being) pregnant and/or breastfeeding, have bleeding disorders, pacemakers and/or surgical hardware prior to receiving treatment.

I understand chiropractic provides relief from pain and presenting symptoms without the use of drugs or medication. Although chiropractic treatments are generally safe and gentle, there are certain, very infrequent, complications, which may arise during and/or after the visit. These risks include but are not limited to soreness, sprains/strains, fractures, dislocations, aggravation of disc injuries, cerebral vascular accidents, soft tissue injuries; localized bruising, swelling, or possible aggravation of symptoms that existed prior to treatment. These complications are extremely rare occurrences.

I understand that my chiropractor will explain to me the exact nature of any treatment provided. I understand that Optimum Care Therapy & Dr. Senkosal Uy do not promise a cure for any symptom, disease or condition as a result of treatment. I do not expect the doctor to be able to anticipate and explain every risk or potential complication of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures that they feel at the time to be in my best interest.

As a patient of Optimum Care Therapy & Dr. Senkosal Uy, I understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative courses of action. I am always at liberty to seek or continue care from another qualified healthcare provider, but at this time, I choose chiropractic.

I understand the cancellation policy requires me to cancel a booked appointment 24 hours prior to that appointment. If I fail to do so, a cancellation fee of $35 will be charged. I accept full responsibility for any fees incurred during care and treatment. In instances of repeated non-compliance, Optimum Care Therapy Chiropractic & Dr. Senkosal Uy reserve the right to discontinue care.

My signature on this form indicates that I have read and understand the preceding information and policies. I understand that if I have any questions about this information, I should ask my chiropractor. I am comfortable with the information provided and voluntarily consent to chiropractic and management on that basis. I hereby release Optimum Care Therapy, Dr. Senkosal Uy, and his staff from any and all liability, which may occur in connection with the above mentioned procedures. I understand that I am free to discontinue participation in these procedures at any time.

_____

Patient (Parent/Legal Guardian) Name Signature Date