REGISTRATION

ORTHOPEDIC THERAPY

Date _____

Name _____ **Age** _____
Address _____ **City**_____ **State**_____ **Zip**_____
1 Mobile #_____ **2 Home#**_____**3 Work#**_____

Best Contact # 1 2 3

E-Mail _____

Date of Birth_____ Primary Care Physician_____

Male / Female Married / Single / Divorced / Widowed Student Yes / No

Employer _____ Phone _____ Contact Person _____

Emergency Contact _____ Phone #_____

Date complaint began _____ similar symptoms before? Yes / No

If Yes, When

_____

_____

_____

Financial Responsibility: You are responsible for any charges/money due for services supplied by this office as part of any/all management of your treatment and health care.

I understand that I am fully responsible for my account. Upon default I am also responsible for any all reasonable collections and/or attorney fees, including a non-show or inadequate cancellation fee of $25.00 in any/both cases.

Signature:

_____

Name: _____ **Date:** _____

Please describe your current complaint – be very specific and include all areas:

_____
_____
_____
_____

Have you seen another doctor/therapist for this complaint? **Yes** **No**
If yes, Who? _____
Treatment?
_____
List all previous surgeries of any type? _____
List all previous medical conditions treated by a doctor, including any current illness/conditions:

The current problem began: **Gradual** **Suddenly**

The cause of the current problem: _____

NECK PAIN: **Describe area / side:** _____

Constant	**Frequent**	**Occasional**	
Mild	**Moderate**	**Severe**	**Extreme**
Dull	**Sharp**	**Burning**	**Stabbing**
Ache	**Other:** _____		

MID BACK PAIN: **Describe area / side:** _____

Constant	**Frequent**	**Occasional**	
Mild	**Moderate**	**Severe**	**Extreme**
Dull	**Sharp**	**Burning**	**Stabbing**
Ache	**Other:** _____		

LOWER BACK PAIN: **Describe area / side:** _____

Constant	**Frequent**	**Occasional**	
Mild	**Moderate**	**Severe**	**Extreme**
Dull	**Sharp**	**Burning**	**Stabbing**
Ache	**Other:** _____		

OTHER AREAS: **Describe area / side:**
_____

Constant	**Frequent**	**Occasional**	
Mild	**Moderate**	**Severe**	**Extreme**
Dull	**Sharp**	**Burning**	**Stabbing**
Ache	**Other:** _____		

It moves from the: _____ **to:** _____

The pain is worse: **Morning** **Evening** **Daily Activities** **Increased Activities**

The pain interferes with: **Work** **Sleep** **Daily Activities** **Other:** _____

Pregnant: **Yes** **No** **Headaches?** **Yes** **No** **If Yes, describe how often:** _____

C. Steven Valenzuela
1244 William D. Tate Ave
Grapevine, Texas
817-305-6548
TIN 56-2585232

PRIVACY NOTICE AGREEMENT

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment and health care operations.

With my signature below, I give consent for Mr. C. Steven Valenzuela to use and/or disclose information about me (or for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have the right to request restrictions on how my information is used/or disclosed in order to execute treatment, payment and health care operations. While Mr. Valenzuela is not required to agree to the restrictions, he is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to Mr. Valenzuela, but revocations cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. Any re-disclosure by said recipient may not be protected by federal privacy law.

Mr. Valenzuela may communicate confidential information to me including any invoices for services, reminders cards, birthday cards, newsletters, and the like, at the address/phone number/e-mail address designated in my registration forms.

I authorize Mr. C. Steven Valenzuela to administer treatment as deemed necessary to treat my problem/condition.

_____ ____/____/____

Patient/Client/Representative