

DR. ALAN J. NUÑEZ
NUNEZ CHIROPRACTIC, INC.
PATIENT REGISTRATION

(This box for office use) *Attending Dr.* _____ *Date:* _____ *Patient ID* _____
INFO. PACK GIVEN _____ *E-mail entered* _____

When completing the following information, please print clearly.

PATIENT INFORMATION:

First Name _____ *MI* _____ *Last Name* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Age _____ *Sex* _____ *Birth date* _____ *Social Security #* _____ *Marital Status (S M W D)*

Occupation _____ *Employer* _____

Work Address _____ *City* _____ *State* _____ *Zip* _____

Daytime phone # _____ *Evening phone #* _____ *Mobile #* _____

e-mail address _____ *Referred by* _____

Date _____ *Signature* _____

ALAN J. NUNEZ, D.C.
NUNEZ CHIROPRACTIC, INC.

FINANCIAL AGREEMENT as of January 1, 2022

All balances are due and payable in full at the time of treatment, unless previous arrangements have been made with this office.

FEE SCHEDULE:

1.	Initial consultation, complete exam, and 1st treatment	\$250.00
2.	Regular office visit including chiropractic treatment 20-30 min.	\$135.00
3.	Extended (1hour) office visit including chiropractic treatment	\$240.00
4.	Physical Therapy (ultrasound, massage, therapeutic exercise, etc.)	Fees vary
5.	X-rays are performed at an outside facility	Fees vary by area x-rayed
6.	Supplements, books and orthopedic supplies	Fees vary
7.	Medicare: Initial exam, and 1st treatment	\$200.00
8.	Medicare: Regular office visit--chiropractic treatment	\$100.00
9.	Medicare: (1 hour) office visit--chiropractic visit extended	\$200.00
10.	Children under 18 and full time students, initial exam and treatment	\$200.00
11.	Children under 18 and full time students, regular treatment	\$100.00
12.	Children Initial Exam 12 years & under –	\$100.00
13.	Children 12 years and under, regular treatment	\$50.00

INSURANCE:

Chiropractic care is covered by many insurance plans. Patients who carry any form of medical insurance should know that all services furnished are charged directly to the patient and that he/she is personally responsible for payment. Therefore, it is customary to remit payment on the day of treatment. The statement you will receive has all the information needed for you to be reimbursed by your insurance company. Simply attach one copy of each receipt to your insurance form and mail it in.

Policy for missed appointments:

1. Rescheduling with 24 hours notice — no charge.
2. Rescheduling to a different time slot during the same day if possible - no charge.
3. Rescheduling to a different day or canceling an appointment without 24 hours notice - \$70.00
4. Missed student/senior appointment without a phone call - \$50.00.
5. Missed regular appointment without a phone call - \$70.00.
6. 1 Hour appointments require **48 business hour notice to reschedule** and if inadequate notice is given the fee is - \$120.00

Without adequate notification, it can prevent other patients in need from using that time space.

I, the undersigned, have read this financial agreement. I understand that I am personally responsible for full payment of my balance at the time of treatment. In the event that my account is a personal injury claim, and the insurance carrier makes no payment or only partial payment on the claim, I understand that I am personally responsible for the entire balance due. I also authorize the release of any information necessary to process any claims.

Patient's signature_____Date_____

REQUIRED FOR YOUR CASE HISTORY

DATE: _____

PxNo.

NAME: _____

Is your condition due to an accident or injury?

Did you injure yourself at work?

Are your current complaints the result of an automobile accident?

Have you been involved in an auto accident in the past? . .

Have you had previous chiropractic care?.....

Have you had X-Rays taken in the last two years?

Are you taking prescription or non prescription drugs?

Are you taking vitamins?

Have you had any surgeries?

Have you been hospitalized?

Have you suffered fractures?

Have you suffered slip-and-fall injuries?

Do you follow an exercise program?

History of cancer?

Rate your diet as: (circle) healthy, mediocre, or poor

Please check the type of care desired so that we may be guided by your wishes when possible

PAIN RELIEF ONLY

PAIN RELIEF AND IMPROVED HEALTH

Please explain to the best of your knowledge what has caused your pain.

Please be as accurate as possible explaining in detail exactly what you were doing, especially the body motion involved. Also lbs. lifted, reaching, bending, twisting, etc.

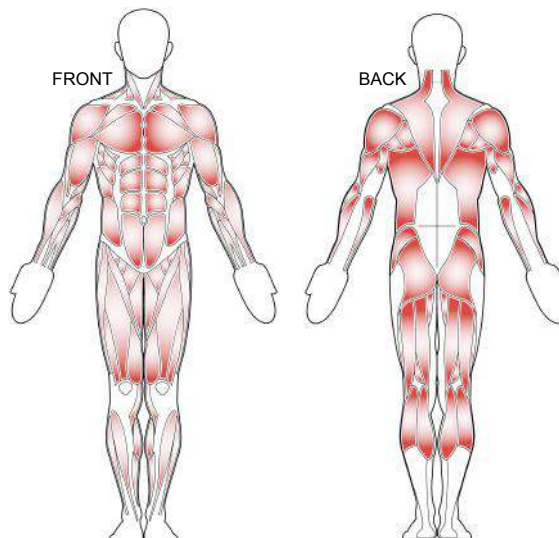
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Numbness = =

Pins and needles 0 0 0

Dull ache X X X

Sharp Pain / / /



Patient's Signature _____

(Please continue on other side of paper)

SYMPTOMS

Please mark L, R or B (left, right, both)

HEAD

☐ Headache
☐ Entire head
☐ Back of head
☐ Forehead
☐ Temples
☐ Migraine
☐ Head feels heavy
☐ Lightheadedness
☐ Fainting
☐ Light bothers eyes
☐ Loss of smell/taste
☐ Dizziness
☐ Jaw pain
☐ Loss of hearing
☐ Ringing in ears
☐ Vertigo
☐ Sinusitis

NECK

☐ Pain in Neck
☐ Neck pain with movement
☐ Pinched nerve in neck
☐ Neck feels out of place
☐ Stiff neck
☐ Muscle Spasms
☐ Grinding/Popping sounds
☐ Arthritis in neck

MID-BACK

☐ Mid-back pain
☐ Pain between
shoulder blades
☐ Sharp stabbing
pain in mid-back
☐ Muscle spasms
☐ Rib pain

CHEST

☐ Chest pain
☐ Shortness of breath
☐ Pain around ribs
☐ Breathlessness
☐ Asthma
☐ Bronchitis
☐ Allergies

LOW BACK

☐ Low back pain
☐ Pain is worse when
 ☐ working
 ☐ lifting
 ☐ stooping
 ☐ standing
 ☐ sitting
 ☐ bending
 ☐ coughing
 ☐ other: _____
☐ Arising from stool
☐ Pinched nerve
☐ Slipped disc
☐ Low back feels out of place
☐ Muscle spasms
☐ Arthritis
☐ Tailbone pain

ABDOMINAL

☐ Stomach upset
☐ Ulcers
☐ Indigestion
☐ Gastritis
☐ Bloating
☐ Constipation
☐ Diarrhea
☐ Colic (for babies)

SHOULDERS

☐ Pain in shoulder joints
☐ Bursitis
☐ Can't raise arm
 ☐ above shoulder level
 ☐ over head
☐ Tension in shoulders
☐ Pinched nerve in shoulders

ARMS & HANDS

☐ Pain in upper arm
☐ Pain in forearm
☐ Pain in hands
☐ Pain in fingers
☐ Fingers go to sleep
☐ Hands cold
☐ Swollen joints in fingers
☐ Loss of grip strength
☐ Stiff joints
☐ Sweaty palms
☐ Tennis/golfer's elbow
☐ Carpal Tunnel Syndrome

HIPS, LEGS & FEET

☐ Pain in buttocks
☐ Pain in hip joint
☐ Pain down leg
☐ Leg cramps
☐ Pins & needles in leg
☐ Numbness of leg
☐ Feet feel cold
☐ Painful joints in toes
☐ Pain in knee
☐ Pain in foot
☐ Plantar Fascitis
☐ Groin pull
☐ Cracked heels

GENERAL - PRESENT OR PAST

☐ Nervousness
☐ Irritable
☐ Depressed
☐ Fatigue
☐ Generally feel run-down
☐ Loss of sleep
☐ Weight gain
☐ Weight loss
☐ Use pillow under legs at night
☐ Jaw pain from chewing gum
☐ Anxiety
☐ Other: _____
☐ Incontinence/bladder leakage
☐ Frequency/urgency

Women Only:

Date of last period: _____ Menstrual pain? _____ Cramping? _____
Severe PMS? _____ Are you now pregnant? _____ If yes, how long? _____
Infertility? _____ Menopause? _____ Hot flashes? _____ Painful breasts? _____