The Diagnostic and Injury Center of Houston, LLC

PATIENT INFORMATION

Date ______________________

Name_______________________________________

Address:____________________________________

City ______________State __________Zip_________

Sex: ☐ M ☐ F Age_____Birth Date______________

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SSN________________________________

Driver's License # __________________State_______

Occupation _________________________________

Employer __________________________________

Employer's Address__________________________

City ______________State __________Zip_________

Employer's Phone____________________________

Spouse's Name______________________________

Spouse's Birth Date__________________________

SSN_______________________________________

Spouse's Occupation _________________________

Spouse's Employer___________________________

Referring/primary Doctor_____________________

PHONE NUMBERS

Home____________Work______________Ext.____

Cell: ______________________________________

Email: _____________________________________

IN CASE OF EMERGENCY, CONTACT

Name___________________Relationship__________

Address:____________________________________

City _______________State________Zip__________

Home Phone___________Work _________________

Cell Phone__________________________________

INSURANCE

Are you covered by a Major Medical Plan? ☐ Yes ☐ No

What is the name of the plan? _______________________

Who is the primary subscriber? ______________________

Relationship to the patient: ______________________

Policy #:_______________Phone #:_________________

If Auto Involved In Injury:

Do you have insurance on your vehicle? ☐ Yes ☐ No

Who is the policy holder? ___________________________

Who is the insurance company? ______________________

Do you have full coverage? ☐ Yes ☐ No

Do you have PIP? ☐ Yes ☐ No

Policy #:_______________Phone #:_________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I or my dependent have insurance coverage and assign directly to The Diagnostic and Injury Center of Houston, LLC all insurance benefits/proceeds, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, my attorney if applicable, or third party claim. I hereby authorize the doctor to release any/all information/records necessary to secure the payment of benefits. I hereby authorize The Diagnostic and Injury Center of Houston, LLC to release all medical information to my attorney (if applicable), third party insurance company, and/or third party attorney (if applicable), at their request. I authorize the use of this signature on all insurance submissions.

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Responsible Party Signature

_______________________ ____________________

Relationship Date

TRAUMA TYPE INFORMATION

Is your condition trauma induced? ☐ Yes ☐ No

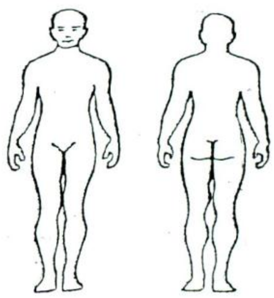
Type of trauma ☐Auto ☐ Work ☐Home ☐Other

To whom have you made a report of this Trauma?

☐Auto Ins. ☐Employer ☐Worker's Comp ☐Police ☐Attorney

Attorney Name (if applicable) ____________________

PATIENT CONDITION



Reason for your visit____

When did your symptoms appear?_______________________________________

Mark an X on the picture where you continue to have pain, numbness or tingling.

Type of pain: ☐ Sharp ☐ Dull ☐Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform are: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other________________

Name and address of other doctor(s) who have treated you for your condition________________

Date of Last: Physical Exam________ Spinal X-ray ________ Blood Test________
Spinal Exam ________ Chest X-ray________ Urine Text________
Dental X-ray ________ MRI, CT-Scan, Bone Scan________

Place mark to indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Weight Loss
- ☐ Whooping Cough

Other________________

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking Packs/Day________
- ☐ Alcohol Drinks/Week________
- ☐ Coffee/Caffeine Drinks Cups/Day________
- ☐ High Stress Level Reason________

Are You Pregnant? ☐ No ☐ Yes Due Date________________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATION	ALLERGIES	VITAMINS/HERBS/MINERALS
________	________	________
________	________	________
Pharmacy________	________	________
Phone ________	________	________