

# ROSENTHAL CHIROPRACTIC

## *Natural Medicine Clinic*

3530 FOREST LANE, SUITE 104, DALLAS, TX 75234

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### ***OUR FINANCIAL POLICY***

We are committed to the successful completion of your treatment program. Please understand the payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Full payment is expected at the time of service. We accept cash, checks, Visa, MasterCard, and American Express. We do not accept assignment of insurance, but do provide you with the necessary paperwork so that you may be re-imbursed by your insurance company.

We realize that due to the rising cost of healthcare, it makes it very difficult for the average person to receive often needed care. It is therefore our policy that no person will be turned away due to financial burdens.

### ***REGARDING INSURANCE***

Our policy is to recommend what is best for each patient. What an insurance company may or may not re-imburse is between the patient and the patient's insurance company. This office will not and cannot set its recommendations by what an insurance company's policy may be. This office will not enter into dispute with an insurance company regarding reimbursement. This is the patient's responsibility.

We do not know if your policy covers chiropractic care or not, and make no representations that yours does. Some insurance policies now cover chiropractic care and they range from a large deductible and a percentage of the bill to a no deductible and 100% of the bill.

### ***SCHEDULING OF APPOINTMENTS***

One of the most precious gifts is our time. To heal in a timely fashion it is important that you keep your appointments as scheduled by your doctor. Schedule ahead as this will assure you of getting the appointment time you want, and the care you need and deserve. Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

We are here to help you. Remember, neither one of us has anything to gain if you delay treatments for financial reasons. We will do everything possible to make your care affordable so that you can follow through on your treatment schedule.

I hereby authorize Dr. David Rosenthal to examine me for my health complaints and give authority for these procedures to be performed. Dr. Rosenthal will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnoses.

I have read the financial policy. I understand and will abide to the terms of the agreement here within.

Name of Patient: \_\_\_\_\_ (Please print)

Signature of Patient: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# DR. DAVID ROSENTHAL, DC, CSCS

3530 FOREST LANE, SUITE 104, DALLAS, TX 75234

## PATIENT CASE HISTORY

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status:  Single  Married  Partner  Divorced  Widowed  Separated

Home Address: \_\_\_\_\_ Number of children: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Work Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ Pager#: \_\_\_\_\_

Employer: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Driver's License #/State: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_ Spouse's Age: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ Pager#: \_\_\_\_\_

Spouse's S.S.#: \_\_\_\_\_ Spouse's Driver's License #/State: \_\_\_\_\_

Referred by: \_\_\_\_\_ Relation: \_\_\_\_\_

Past Chiropractic Care:  Yes  No Who/When: \_\_\_\_\_

Please list the region(s) of complaint(s) and severity or severities of complaint(s) below. Please note the severity on a scale of 1 to 10 (1-Least; 10-Greatest): i.e. headaches, worse with movement

1 2 3 ④ 5 6 7 8 9 10

1. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

4. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

2. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

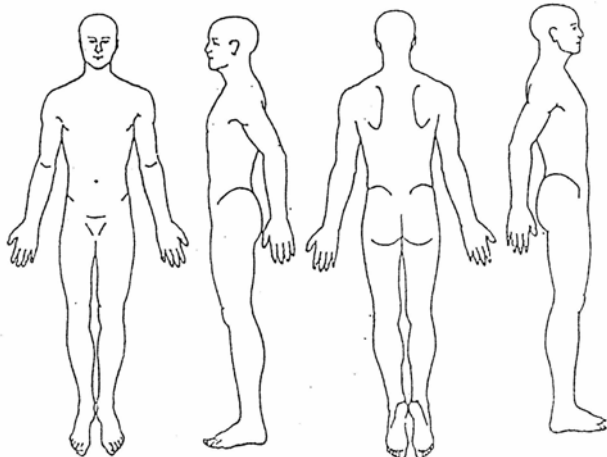
5. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

3. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

6. \_\_\_\_\_  
1 2 3 4 5 6 7 8 9 10

Using the letters below (A, B, N, T, S, & O) draw the location of your complaint on the body outline below:

Aching or dull	Burning	Numbness	Tingling/Pins/Needles	Sharp/stabbing	Other
<b>A</b>	<b>B</b>	<b>N</b>	<b>T</b>	<b>S</b>	<b>O</b>



Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

List health problems that you are currently being treated for:

\_\_\_\_\_  
\_\_\_\_\_

What types of therapy have you tried for this problem(s)?

- Acupuncture       Conventional drugs       Enemas       Herbs       Vitamins/minerals
- Chiropractic       Diet modification       Fasting       Homeopathy       Other \_\_\_\_\_

Are you presently taking any medications (prescription or over the counter)?  No  Yes Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your current stress level? Please circle, 1 is lowest, 10 is highest: 1 2 3 4 5 6 7 8 9 10

Have you recently lost or gained 10 pounds or more over the last 3-4 months?

\_\_\_\_\_

Are your present problems due to an injury?  No  Yes  Auto  On the job  Personal injury  Other \_\_\_\_\_

Have you made a report of your accident?  No  Yes  Auto  Employer  Workers compensation  Other \_\_\_\_\_

Are you now or have you been disabled (Service or work)?  No  Yes When?: \_\_\_\_\_

Have you retained an attorney?  No  Yes (Name and Address): \_\_\_\_\_

List any accidents or falls and dates  Car \_\_\_\_\_  Recreational vehicle \_\_\_\_\_

Sports \_\_\_\_\_  School \_\_\_\_\_  Other \_\_\_\_\_

List any broken bones(fractures) or dislocations: \_\_\_\_\_

Have you had any surgeries?  No  Yes Explain: \_\_\_\_\_

Have you ever had any spinal taps or spinal infections?  No  Yes Explain: \_\_\_\_\_

Were you ever knocked unconscious?  No  Yes Explain: \_\_\_\_\_

Have you ever had a lapse of memory?  No  Yes Explain: \_\_\_\_\_

Have you ever had x-rays taken?  No  Yes Explain: \_\_\_\_\_

Have you ever worked with toxic chemicals (dentistry, photo lab, gas station, etc.)?  No  Yes Explain: \_\_\_\_\_

\_\_\_\_\_

Any recent changes in your ability to:  See  Hear  Taste  Smell  Feel hot/cold sensation  Move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers, etc.)

Do you suffer from any condition other than that for which you are now consulting us?  No  Yes Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_