

Dr. Steven Ross, D.C., F.A.S.B.E., D.A.A.P.M.
12070 Carmel Mountain Road, Suite 290
San Diego, CA 92128
Tel; 858-676-1166, Fax; 858-433-0508

Please Print Clearly And Fill In Completely. Today's Date _____

Print Name _____ What do you prefer to be called? _____
Street Address _____ City _____ State _____ Zip _____
Phone/ Home _____ Work _____ Cell _____
Date of Birth _____ E-mail Add: _____ @ _____
Occupation _____ Employer _____
Employers Address _____ City _____ State _____ Zip _____
How were you referred to our office? _____
Is this injury/illness related to an automobile accident? _____ (If yes, please complete the accident/injury form along with this form)
Please Check ✓ Sex: Male Female Married Single Divorced Widowed

Which services are you seeking out today?

Chiropractic Functional Medicine Massage Weight Loss Nutritional Counseling
****Please complete additional intake form for the services requested in addition to this form****

Health History:

Give reason for consulting our center today: _____
Describe any health problems, including how long you've had them: _____

Are you under the care of any other doctor? Yes No

If Yes, the conditions being treated for: _____

List any current Medications: _____

List any past surgeries & dates: _____

List any past accidents & dates: _____

List any x-rays you've had in the past 2 years: _____

Personal & Family History:

Significant others health status _____

Number and age of children's ages and health status: _____

Health History & Your Health Objectives:

In addition to the main reason you are here today for, what additional health objectives do you have for your future?

Have you ever been to another doctor who has put you on a Health Development Program? Yes No

If yes, Who? _____ MD DC Other _____

What were the results? _____

Were the results permanent? Yes No don't know

Are you as healthy today or healthier than you were 5 years ago? Yes No don't know

If you had been put on a Health Development Program in the past, what strategies have you used?

Do you feel you will stay as healthy as you are today 5 years from now? Yes No don't know

If yes, what strategies will you implement to get there? _____

Wellness Commitment

At Balboa Wellness Center, we are dedicated toward achieving the goal of total lasting health for our patients. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10% ----- 20% ----- 30% ----- 40% ----- 50% ----- 60% ----- 70% ----- 80% ----- 90% ----- 100%

Where did you hear about our clinic, or who referred you? _____

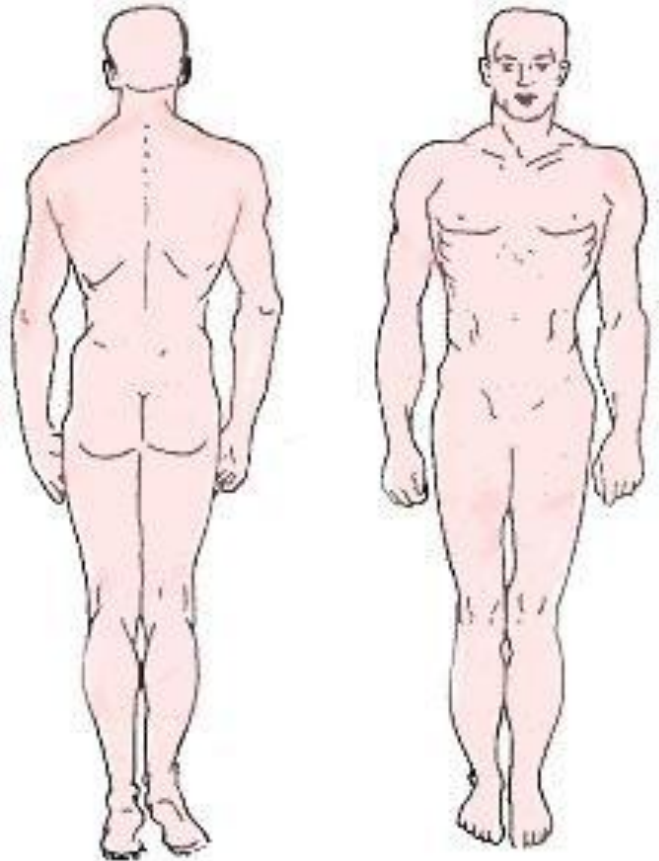
FEMALES: Please Check One ✓ Is there a possibility of you being pregnant? Yes No

Please Complete The Following

If you have had the following, or if you suffer from the following, Please Check ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Circle the areas where you have any problems. Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

AUTO ACCIDENT INFORMATION

Date of accident: _____ Time: _____ am/pm

Were you ___ driver, ___ passenger, ___ front seat, ___ back seat

Number of people in vehicle ____, Were you wearing a seatbelt? yes/no

Make, model and year of car you were in: _____

Make, model and year of other car: _____

Where did the accident happen (street name, direction of travel)? _____

What part of the car was hit? _____,

Did you hit anything within the car on impact (what part of your body)? _____

Did you lose consciousness? yes/no. How did you feel after the impact? _____

Were paramedics called to the scene? yes/no Were you taken to a hospital? yes/no.

Name of hospital and doctor seen: _____

Treatment provided: _____

Medical advice following: _____

FINANCIAL POLICY

As is customary with professional services, payment is expected at the time of service. If you are in need of payment arrangements, please let the front desk know prior to your visit today. All services rendered are charged directly to you and you are personally responsible for payment. If you have insurance, upon presentation of your insurance card to our billing department, we will be happy to call and inquire as to your benefits for services at our clinic. We will also be happy to submit charges incurred, however, you are ultimately responsible for all charges.

PRIMARY INSURANCE

Name on Policy: _____ Policy Number: _____

Group Number: _____ Claim Number: _____

Ins. Co. Add.: _____, City: _____, State: _____, Zip: _____

Ins. Adjusters Name: _____, Phone: _____, Fax: _____

OTHER INSURANCE

Name on Policy: _____ Policy Number: _____

Group Number: _____ Claim Number: _____

Ins. Co. Add.: _____, City: _____, State: _____, Zip: _____

Ins. Adjusters Name: _____, Phone: _____, Fax: _____

ATTORNEY INFORMATION (If Retained)

Name: _____, Phone: _____

Add.: _____, City: _____, State: _____, Zip: _____

CANCELING APPOINTMENTS

So that we may provide sufficient time for all of our patients, we appreciate a 24-hour cancellation notice for all scheduled appointments. Failure to provide advanced cancellation notice will result in a \$25.00 cancellation fee. Please keep in mind that this fee cannot be submitted to your insurance company.

ASSIGNMENT OF BENEFITS

This form will instruct and direct your insurance company _____
To pay by check made out and mailed directly to:

Dr. Steven Ross, D.C., F.A.S.B.E., D.A.A.P.M.
12070 Carmel Mountain Road, Suite 290
San Diego, CA 92128
Tel; 858-676-1166, Fax; 858-433-0508

If my current policy prohibits direct payment to the doctor, then, I hereby instruct and direct you to make the check payable to me and mail it as follows to:

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This includes the professional and medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

A photo copy of this agreement and assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at San Diego, California this _____ day of _____ 200 ____

Signature of policy holder

Office staff signature

Signature of claimant if other than policyholder

Consent to Initiate Care

At this clinic, we have one simple goal. We want to render the highest quality health care to each and every patient. In order to accomplish this goal, we have altered some business procedures in this clinic to keep our fees reduced. Please read over these procedures below to understand how our clinic functions, and to decide if you wish to participate. If you have any questions please direct them to the receptionist.

1. We will submit receipts to your insurance company or other third-party health care programs for reimbursement, but payment for such services by insurance companies is neither implied nor agreed to by Ross Health and Wellness and takes *no responsibility* for non-payment by insurance companies for services rendered at our clinic.
2. No balances can be kept or run by patients at any time.
3. All visits are paid at the time of service being rendered.
4. Our clinic reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.
5. In order to get the results you desire, it is necessary that you keep your appointments as scheduled.

I wish to initiate care at Ross Health and Wellness. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name _____ **Today's Date** _____

Sign your name _____