3960 Ivywood Lane
Pueblo, CO 81005
(719) 565-1276
Fax: (719) 565-2313

Welcome to Avila Integrative Medicine

- If you will be paying **CASH**, payment is expected at the time services are rendered unless prior arrangements have been made. ***We accept Cash/Check/Credit Card/Debit Card.***

- If we will be billing your **INSURANCE** we will need the following information:

  1. Copy of your Current Insurance Card
  2. Copy of your Current Driver License

Prior to your appointment with our facility, we will be happy to verify your coverage and discuss any deductible/co-pay information.

- If your insurance is **MEDICARE** we will need the following information:

  1. Copy of your Current Medicare Card
  2. Copy of your Current Driver License
  3. Copy of your Supplement Insurance

Please read, sign and date the attached form.

- If you were injured in an **AUTO ACCIDENT** we will need the following information:

  1. Claim number assigned by **the responsible** insurance company.
  2. A copy of the accident report.
  3. A copy of your proof of insurance card.
  4. A copy of your auto policy.
  5. A copy of your Current Driver License.

Once your claim is processed, the insurance company will send you some paperwork. We can assist you with these forms and we would like a copy of the assignment of benefits form.

Thank You!

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PATIENT ADMITTANCE FORM

Full Name ____ Date ____________
Address ________________________________City ___________State ______ Zip _______
Phone (Home) ________________ (Work) _________________Cellular: ______________
Date of Birth ____________Sex _____ Marital Status ______ Email:__________________
Occupation ______________________Children (Ages) ______________________________
Employer ___________________ Employer Address ______________________________
Social Security # _________________ Drivers License # ______________ State __________
How did you hear about our office ______________ Name of Personal Physician __________
Nearest relative not living with you (Emergency Contact) Name _____________________
Relationship ___________ Phone ___________ Address ______________________________

ACCIDENT WORK RELATED INJURY INFORMATION

Can you relate your symptoms to any specific event/activity? □ Yes □ No Date of event/activity: ___/___/___
If yes, please describe: ____
Are your present problems due to an accident-injury? ___________________________
Type of accident-injury (circle): Auto On-the-Job Sports Military Household Slip & Fall Personal Other
Name of attorney handling your case ____________ Address __________Phone __________

INSURANCE INFORMATION

Type of insurance you plan to use (circle): Auto On-the Job Company Group Personal Group Medicare Other
Insurance Co. ___________________ Address______________________ Phone _________
Agent _______________ Policy # ____________ Claim # ____________ Group Plan _______
Insured's Name ____________________________ Insured's Date of Birth _______________
Spouse's Name _________________________ Spouse's Employer _____________________
Spouse's Occupation __________________________ Spouse's Social Security # ___________
Spouse's Insurance or other insurance you may use:
Insurance Co. ________________________ Address __________________________________
Policy # __________________ Claim # _____________________ Group Plan ____________

TREATMENT AUTHORIZATION

I hereby authorize this office, its staff, and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount be necessary, I will become responsible for all charges, fees, and attorney fees.

Patient's Signature (X) ______________________________________ Date ____________

CONSENT TO TREAT A MINOR

I (we) being the parents, guardian or custodian of the minor being ________________, Age ______, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for services and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them.

Parent, Guardian, or Custodian Signature ___________________________________ Date _________

Witness ____ Date _________

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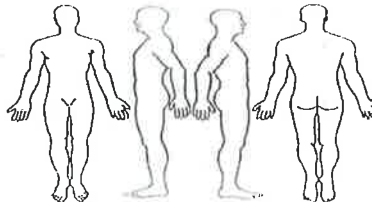
MAJOR COMPLAINT

What is your major complaint (Exact Description) ______________________________
____
____
____

Is it related to a fall or accident? (describe) ______________________________
How long have you had this condition? ______________________________
Have you had similar conditions in the past? ______________________________
The condition is (circle): Worse Same Better Consistent Recurring
How does this condition interfere with your work or daily routine? ______________________________
When is your condition worse? (circle): Morning Afternoon Evening Night
What aggravates your condition? ______________________________
What relieves your condition? ______________________________
Names of other doctors seen for this condition ______________________________
Name of Hospital (if applicable) ______________________________
Previous diagnosis for this condition ______________________________
Type of previous treatment and/or surgery for this condition ______________________________
Duration of previous treatment for this condition ______________________________
Result of previous treatment (circle): Good Fair Poor Other ______________________________

Please indicate on the diagram the areas where you are experiencing symptoms using the suggested marks below to describe your symptoms:

Pain ^^^^
Numbness = = =
Pins & Needles 0 0 0
Burning X X X
Stabbing / / / /



Using the scale, what is your pain TODAY (please circle):
0 1 2 3 4 5 6 7 8 9 10
No pain --------------------Worst Pain Imaginable

Please list your symptoms in order of their severity, most significant or painful symptoms first:

	Symptom(s)	Date
1.	______________________________	___/___/___
2.	______________________________	___/___/___
3.	______________________________	___/___/___
4.	______________________________	___/___/___
5.	______________________________	___/___/___

□ Yes □ No **Have you received treatment for these symptoms in the past? If yes, please answer the following, beginning with your most recent treatment:**

1. **Name and location of provider:** ______________________________
   Date(s) seen: ____________ **How many times?** ____________
   Treatment received: □ Physical therapy/exercise □ Massage □ Chiropractic □ Injections □ Surgery
   □ X-Rays, CT scans, MRI: Which body areas? ______________________________
   □ Prescriptions or medications? (please list): ______________________________

X______________________________ ____________________
(Patient Signature) **(Date)**

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Patient Name: ________________________________ Date: ______________

Symptoms

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision - halos

SKIN
- ☐ Bruises easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period __________
Date of last Pap Smear __________
Have you had a mammogram? __________
Are you pregnant? __________
Number of children __________

Previous/Current Health Conditions

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-Immune Disease
- ☐ Bleeding Disorders
- ☐ Birth Defects
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cervical Whiplash
- ☐ Chemical Dependency
- ☐ Concussion
- ☐ Convulsions
- ☐ Cyst
- ☐ Diabetes
- ☐ Dislocation
- ☐ Ear Infections
- ☐ Electronic Implant
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractured Bone
- ☐ Glaucoma/Cataracts
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Joint replacement
- ☐ Knocked Unconscious
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Metal Screws/Implants
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis/Osteoarthritis
- ☐ Ruptured Spinal Disc
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Slipped Spinal Disc
- ☐ Spinal Surgery
- ☐ Spinal Injections
- ☐ Spinal Taps
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Other Diseases/Problems with the neck and/or back
- ☐ Other __________

Medications

____
____
____

Allergies

____
____
____

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Health History

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates ______________________________

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications, if any

Health Habits

Check which substances you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Drugs	
	Other	

Conditions

Check if your work exposes you to the following:			
	Stress		Hazardous substances
	Heavy Lifting		
Occupation			

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature ______________________ Date ______________

Reviewed By ______________________ Date ______________

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CONSENT TO CHIROPRACTIC TREATMENT
AUTHORIZATION FOR RELEASE OF INFORMATION FOR MEDICAL RECORDS

All references herein to Doctor mean and include **Avila Integrative Medicine and Dr. Robert J. Avila D.C., CCST,CCCN**. All references herein to **"Patient"** mean and include the patient and any other person acting on behalf of the patient.

The patient is: ____

PATIENT ACKNOWLEDGES THE READING OF THIS AGREEMENT, THAT IT HAS BEEN FULLY EXPLAINED, AND THAT IT IS FULLY UNDERSTOOD REGARDING CONTENTS, HAS RECEIVED A COPY THEREOF, AND THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Insured/Patient Signature: ______________________________Date: ___________

Witness: ____

If the patient is a minor or for any reason is unable to consent because of physical disability or incompetence, complete the following:

The patient is unable to consent because: ______________________________

Person with Authority to Consent for Patient: ___________________________

Relationship: __________________ Witness: ________________________

- **Chiropractic, Therapeutic, Nutritional, and Rehabilitative Care Consent**: The patient who is suffering from a condition requiring Chiropractic care, diagnostic, or chiropractic treatment does hereby voluntarily consent to and authorize such chiropractic care and diagnostic services, including but not limited to x-ray, chiropractic diagnostic or non-invasive procedures, which may be preformed under order from: **Dr. Robert J. Avila, D.C.,CCST, CCCN** his assistants or designee as is necessary in their judgment.

- **No Guarantee**: I am aware that the practice of chiropractic is not an exact science and I acknowledge that no promises or guarantees have been made to me as to the result of treatment to be provided for me by the assistant or my physician.

- **Assignment of Benefits:** I authorize and direct the Insurance Company(s) to pay directly to **Avila Integrative Medicine** all chiropractic insurance benefits otherwise payable to me. I understand that I am financially responsible to **Avila Integrative Medicine** for charges not covered by or paid pursuant to this authorization.

- **Medicare:** Patient certified that the information provided in applying for payment of charges for health care and the services of certain physicians for whom the health care facility is authorized to bill in connection with its services under Title XVIII or Title XIX of the Social Security Act is correct. Patient requests payment of authorized benefits under the Social Security Act be made to **Avila Integrative Medicine** on behalf of the patient and authorizes release of all records of the patient required to act on this request and agree that for such purpose a copy of this agreement may be used in place of the original. Patient herby assigns to **Avila Integrative Medicine** payment for such unpaid charges to those physicians for whom **Avila Integrative Medicine** is authorized to bill in connection with its services.

- **Release of Information:** I hereby authorize **Avila Integrative Medicine** to disclose, as necessary to substantiate claims, any or all parts of my medical records to any person or corporation, which is or may be liable under a contract for all or part of the charges, including but not limited to, my insurance company, any third party payer, providers of services, medical service companies, employer, workmen's compensation carrier, welfare agency, social agency, or governmental agency. I further authorize the release of medical records and medical information to facility personnel for the purpose of treating my chiropractic condition and protecting facility personnel and other patients from any contagious or communicable disease or illness. Information released will done so in compliance with state and federal laws.

- **Financial Agreement:** In consideration of the services to be rendered to patient, and all other persons signing this agreement, jointly and severally, agree to pay (I) in full, all costs, charges and expense of **Avila Integrative Medicine** of every kind and description for service, supplies, vitamins, and other items supplied or furnished by **Avila Integrative Medicine** to or for the benefit of the patient, and (II) all costs of collections, including reasonable attorney fees, and agree that a copy of this Agreement shall be as effective and valid as the original.

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Responsibility For Payment Of X-Ray

Dr. Avila utilizes a 2nd opinion for a radiology consultation with a written report. This further objective data will assist in documenting your injuries and underlying condition.

I fully understand and agree that I am directly and fully responsible to pay **$45.00** in full for x-ray reports.

I further understand and agree that payment is not contingent upon any settlement, claim, judgement or verdict by which I may eventually recover said fee.

Patient/Guardian Signature   Date

Witness   Date