

**Patient Information**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_

Birthday: \_\_\_\_\_

Patients SS#: \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Occupation: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Employers Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer/School Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Phone Numbers**

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Appointment Reminder- **Email, Text or Phone Call?**

Cell Phone Carrier – VZW- Sprint- ATT- Metro- T-Mobile

**Other** \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

**Accident Information**

Is condition due to an accident?  Yes  NO

Date \_\_\_\_\_

Type of accident  Auto  Work  Home

To whom have you made a report of your accident?

Auto Insurance  Employer  Work Comp  Other

Attorney Name (if applicable) \_\_\_\_\_

**List of Medications/Vitamins**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Exercise**

- None
- Moderate
- Heavy
- Daily

**Habits**

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

**Work Activity**

- Sitting
- Standing
- Light Labor
- Heavy Labor

Packs/Day \_\_\_\_\_

Drinks/Week \_\_\_\_\_

Cups/Day \_\_\_\_\_

Reason \_\_\_\_\_

**Are you pregnant?**  Yes  No Due Date \_\_\_\_\_

# Allergies

Height: \_\_\_\_\_

Wt: \_\_\_\_\_

--Latex --Rubber -- KT tape --NSAID --Soaps --None --Other \_\_\_\_\_

# Surgeries

--Abdominal	--Ablation	--Achilles	--Ankle	--Appendix
--Arm	--Back	--Brian/Tumor	--Breast	--Carpal tunnel
--Cataracts	--Cervical Disc	--Chest	--Colon	--Cornea
Transplant				
--C-section	--Disc	--Diverticulitis	-- Ectopic Pregnancy	--EENT
--Elbow	--Endometriosis	--Femur	--Foot	--Gallbladder
--Gastrointestinal	--Gynecological	--Hand	--Heart	--Heart Bypass
--Hemorectomy	--Hernia	--Hip	--Hip Replacement	--Hysterectomy
--Knee	--Intestine	--Jaw/Orthodontic	--Kidney	--Kidney Stones
--Knee Replacement				
--Lumbar Disc	--Lasik	--Liposuction	--Laparoscopy	--Lithotripsy
--Miscarriage	--Lumpectomy	-- Lymphedema	--Lipoma	--Mastectomy
--Nose	--Mole	--Neck	--Neurological	--NONE
--Prostate	--Obstetrical	--Other	-- Ovary	--Podiatric
--Sinus/Jaw	-- Prostatectomy	--Rhinoplasty	--Scar Revision	--Shoulder
thoracic	--Sleep Apnea	-- Spinal fusion cervical	--Spinal fusion	--Spinal fusion
--Stent			lumbar	
Removal	--Thoracic Disc	--Throat	-- Tonsil/s	--Varicose Vein
--Wrist				
	--Wrist/Hand			
--Other _____				

# Medical History

--Alcoholism	--Allergy Shots	--Anemia	--Ankle Pain
--Appendicitis	--Arm Pain	--Arrhythmia	--Arthritis
--Asthma	--Back Pain	--Brachialplexus Palsy	--Breast Lump
--Broken Bones	--Bronchitis	--Cancer	--Carpal Tunnel
--Chemical Dependency	--Chest Pain	--Chicken Pox	--Colon
--Concussion	--Congestive Heart Failure	--Depression/Other disorder	--Diabetes
--Dislocations	--Dizziness	--Elbow Pain	--Emphysema
--Epilepsy	--Eye/Vision Problems	--Fainting	--Falls/Concussion
--Fatigue	--Foot Pain	--Fracture	--Genetic Spinal Disorder
--Goiter	--Gout	--Hand Pain	--Headaches
--Hearing Problems	--Heart Disease	--Hemochromatosis	--Hepatitis
--Hernia	--Herniated Disc	--Herpes	--High Blood Pressure
--High Cholesterol	--Hip Pain	--Jaw Pain	--Join Stiffness
--Kidney Disease	--Kidney Stones	--Knee Pain	--Leg Pain
--Liver Disease	--Low Back Pain	--Lupus	--Measles
--Menstrual Problems	--Mid Back Pain	--Migraines	--Minor Heart Trouble
--Miscarriage	--Mononucleosis	--Multiple Sclerosis	--Mumps
--Neck Pain	--Neurological Disorder	--Neuropathy	--NONE
--Osteoporosis	--Ovarian Cysts	--Pacemaker	--Parkinson's disease
--Pinched Nerve	--Plantar Faciitis	--Pneumonia	--Polio
--Prostate Problems	--Psychiatric Care	--Pulmonary Embolism	--Rheumatic Fever
--Rheumatoid Arthritis	--Scoliosis	--Shingles	--Shoulder Pain
--Significant weight change	--Spinal Cord Injury	--Spondylolisthesis	--Sprain/Strain
--Stomach Problems	--Stroke/Heart Attack	--Thyroid	--Tonsillitis
--Tumor/Growths	--Ulcer/s	--Vaginal Infections	--Vertigo
--Whooping Cough	--Wrist Pain		
--Other _____			

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

What body part are you being seen for today:

Is it:                    Bilateral                    Left                    Right

When did condition start? \_\_\_\_\_

How did it start? \_\_\_\_\_

Do you have any recent imaging ( X-ray, MRI, CT, etc.)? If so please list date and name of facility.  
\_\_\_\_\_

ON A SCALE OF 0-10, WITH 10 BEING UNBEARABLE PAIN, PLEASE RATE YOUR SYMPTOMS:

1            2            3            4            5            6            7            8            9            10

INTENSITY: Minimum   Mild   Moderate   Severe   unbearable

NATURE: Dull ache   Numbness   Radiating pain   Sharp   Shooting   Stabbing   Tightness   Tingling   Throbbing

WHAT HELPS: Acupuncture   Chiropractic   Heat   ICE   Massage   Nothing   Pain Meds   Therapy   Sleep/rest   Stretching   other: \_\_\_\_\_

FREQUENCY: Intermittent 0-25% of the day   Occasional 26-50% of the day   Frequent 51-75% of the day  
Constant 76-100% of the day

ANY ADDITIONAL COMMENTS:

Activities of Daily Living

**Circle each of the activities which you have a difficulty performing and or can perform only with pain.**

- |                      |                      |                                 |
|----------------------|----------------------|---------------------------------|
| Bending              | Gardening            | Personal hygiene/Grooming       |
| Care of others/Pets  | General Mobility     | Pushing/Pulling with legs/feet  |
| Carrying Objects     | Holding onto objects | Pushing/Pulling with hands/arms |
| Climbing Stairs      | Jogging              | Reaching out/up/down            |
| Concentrating        | Keeping balance      | Sitting                         |
| Cooking/Cleaning     | Housework            | Standing                        |
| Crouching/ Squatting | Lifting              | Turning                         |
| Dressing             | Lying Down           | Twisting                        |
| Driving              | Moving Joint/s       | Walking                         |
| Eating               | Exercise/Sports      | Yard Work                       |
| Other Explain: _____ |                      |                                 |

Please initial:

\_\_\_\_\_ Please arrive ten minutes before your scheduled appointment time to ensure a full session.

\_\_\_\_\_ We pride ourselves in not having patients wait and as such need all patients to arrive 10 minutes before their appointment time and no later than their scheduled appointment time. We may have to reschedule your appointment if you are running late.

\_\_\_\_\_ You may cancel your appointment without charge up to 24 hours preceding your appointment. Same day cancellations will be charged 50% of the scheduled service price. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

\_\_\_\_\_ Your next \_\_\_\_\_ visits are for treatment only. In the event that your condition deteriorates, there is re-injury, or new areas need to be addressed please call our office prior to your appointment so we can allow the necessary time for a re-examination by the doctor.

\_\_\_\_\_ When you arrive at the office we have to first check you into our system before you can sign the sign-in pad.

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me ( or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as the back up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

*To be completed by patient*

*To be completed by patient's Representative, if necessary, e.g., if patient is a minor or is physically or legally incapacitated:*

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Patient

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

\_\_\_\_\_  
Print Name of Patient's Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Patient's Representative

To be completed by doctor or staff

Print Name(s) of doctor(s) treating this patient:

Anthony B. Morovati, D.C. and / or  
Janine Abramian, D.C. and / or

Morovati Chiropractic Corp  
Anthony B. Morovati, D.C.  
Janine Abramian-Morovati, D.C.  
3515 North Verdugo Rd.  
Glendale, CA 91208

Staff Signature: \_\_\_\_\_

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

Witness to Patient's \_\_\_\_\_

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

This Signed original is to be filed in patient's file and a copy is to be given to the patient.

Patient Name: \_\_\_\_\_

### Financial Policy

Thank you choosing Morovati Wellness Center as your Chiropractic Providers. We are committed to your successful treatment. We request you read, agree to, and sign the following statement of Financial Policy prior to starting treatment.

1. It is your responsibility to verify with your insurance plan/carrier as to your coverage with them. Although we verify your insurance we cannot be held responsible for the information given as insurance companies read a disclaimer that states that verification of benefits is not a guarantee of payment. Please note that Dr Anthony Morovati is not a contracted provider with any insurance company other than Lakeside Medical Group IPA. Please note that Dr Janine Morovati is not a contracted provider with any insurance company. Please verify that service such as office visits, X-Rays and in-office procedures do not require pre-authorization. Some plans require pre-authorization or referrals from the patient's primary care physician. .

2. Payment is due at the time services are rendered, including co-payment and deductibles. Your insurance is billed as a courtesy but it is not a guarantee of payment. We accept cash, check, Visa and MasterCard.

3. Written or verbal authorizations from insurance plans or management groups are not guarantee of payment. All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances of certain procedures or limit the length of the sessions. Ultimately all charges are your responsibility. Please note that acuscope treatments are time based and are billed in increments of 15 minutes. Furthermore, there is two ways the acuscope can be applied, attended and unattended. When we apply the acuscope attended, we bill for the electric current being applied as well as myofascial release of the trigger points in increments of 15 minutes. When the acuscope is being applied unattended we only bill for the electrical current in increments of 15 minutes. However, keep in mind that the length of time the acuscope is applied is dependent on medical necessity. All supplies, which are not billable to your insurance carrier, must be paid for at the time they are dispensed.

4. Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days. Overdue accounts are subject to a \$15.00 rebilling fee each 30 days it goes unpaid. Accounts 90 days in rear will be subject to collection and/or interest by and external agency unless financial arrangements are made with our office.

5. APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS TO THE SCHEDULED APPOINTMENT TIME WILL BE CHARGED \$85.00 MISSED APPOINTMENT FEE. PLEASE BE SURE TO ADVISE THIS OFFICE 24 HOURS IN ADVANCE OF CANCELLATION. **We ask that you arrive 10 minutes prior to your appointment time to insure you receive your full session.**

6. Whenever our office refers you to outside laboratories, hospitals, physical therapy or tests, be sure to verify that pre-authorization is not required and that your insurance participates with their facility.

7. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Private Insurance, and other health plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

8. I also acknowledge receipt of the notice of Privacy Practices.

I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH.

Print name of the financially responsible party \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Authorization to Release Medical Records**

To: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ hereby authorize and request you to release to:

Anthony B. Morovati, D.C.  
Janine Abramian –Morovati, D.C.  
3515 North Verdugo Rd.  
Glendale, CA 91208  
818-500-8484  
818-975-2869 Fax

Any and all records and/or reports in your possession; including history, x-ray results, diagnosis, and treatment concerning my illness of injury of \_\_\_\_/\_\_\_\_/\_\_\_\_.

Patient's Signature: \_\_\_\_\_

Date \_\_\_\_\_

Social Security # \_\_\_\_\_

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

**CONSENT FOR TREATMENT OF A MINOR**

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

(I) (We) the undersigned, parent (s) or legal guardian (s) of \_\_\_\_\_, a minor, do hereby authorize, **Anthony B. Morovati, D.C. and/or Janine Abramian, D.C.**, as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent (s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until \_\_\_\_\_, unless sooner revoked in writing delivered to said agent (s).

Father: \_\_\_\_\_ Witness: \_\_\_\_\_

Mother: \_\_\_\_\_ Witness: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_ Witness: \_\_\_\_\_



