Andres Galego, D.C.
ABH CHIROPRACTIC
"American Back Health"

Patient #:_____

PATIENT INFORMATION

Name:_____ Age:____ Birthdate: _____
Address:_____ City/State/zip:_____
Social Security#:_____ Home phone#:_____ Cell#:_____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Male ☐ Female
Work:_____ Occupation:_____
Work Address:_____ Work#_____
Best time and place to reach you:_____ email: _____
Spouse's Name:_____ Birthdate: _____SS#_____
Emergency Contact: Name: _____ Home#_____
Work# _____ Cell# _____
Who may we thank for referring you? _____

Date of Injury/Accident:_____ Emergency Treatment Rendered? ☐ YES ☐ NO
If YES, when and where? _____
Were X-rays taken for this problem? ☐ YES ☐ NO

HEALTH INSURANCE

Insurance Co:_____ ID#_____ GROUP#_____
Subscriber's name:_____ ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

WORKER'S COMP

Insurance Co:_____ ID#_____GROUP#_____
Employer:_____ Claim#_____
Contact Person:_____ Contact Number:_____
Was Injury Reported? ☐ YES ☐ NO Place of Injury:_____
Have you missed time from work? ☐ YES ☐ NO If YES, give dates:_____

PERSONAL INJURY

☐ Auto ☐ Driver ☐ Passenger Place of Accident: ☐ MD ☐ VA ☐ DC ☐ Other_____
Your Auto Ins:_____ PIP Filed? ☐ YES ☐ NO
Policy Holder:_____ Claim#_____
Legal Case? ☐ YES ☐ NO Attorney:_____ Phone#:_____
Address:_____

Other Payment Method: ☐ CASH ☐ CHECK ☐ CREDIT CARD Visa( ) Master Card( ) Discover( )

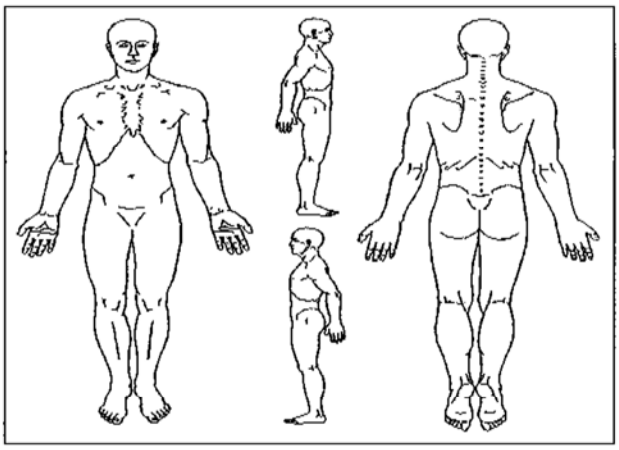
Name on Card:_____ Account#_____ EXP:_____CVC:_____
All accounts not paid within 45 days of service will automatically be put through on your credit card unless other arrangements have been made with this office. I authorize this office to charge any past due balance on my credit card.

Signature:_____ Date:_____

I, the undersigned certify that I (or my dependent) have insurance coverage with_____
And assign directly to Dr. Andres Galego, D.C. (ABH Chiropractic) all insurance benefits for services rendered. I certify that the information I have reported with regards to my insurance coverage is correct. I understand and agree that all services rendered to me are charged directly to me and that I am responsible for all charges whether or not paid by insurance. I authorize Dr. Andres Galego, D.C. (ABH Chiropractic) to release any information necessary to secure the payment of benefits.

Signature of Subscriber or Beneficiary: _____ Date:_____

Place an **X** on the picture where you continue to have discomfort.



Have you ever suffered from:

1.	Dizziness	Yes___	No___
2.	Headaches/Migraines	Yes___	No___
3.	Heart Troubles	Yes___	No___
4.	Diabetes	Yes___	No___
5.	Arthritis	Yes___	No___
6.	Backaches	Yes___	No___
7.	Asthma	Yes___	No___
8.	Neuritis	Yes___	No___
9.	Digestive Disorder	Yes___	No___
10.	Nervousness	Yes___	No___
11.	Sinus Trouble	Yes___	No___
12.	Neck Pain	Yes___	No___
13.	Muscle cramps	Yes___	No___
14.	Clumsiness	Yes___	No___
15.	Loss of sleep	Yes___	No___
16.	Ringing in the ears	Yes___	No___
17.	Difficulty swallowing	Yes___	No___

Health Information

What is your primary concern or symptom? _____
When did this happen or start? _____
How often does it occur? _____
Describe the type of pain or discomfort (dull, sharp,tingling etc): _____
What makes it feel better? _____
What makes it feel worse? _____

What is your secondary concern or symptom (if any)? _____
When did this happen or start? _____
Describe the type of pain or discomfort (dull, sharp,tingling etc): _____
What makes it feel better? _____
What makes it feel worse? _____

Is this condition interfering with your; Work___ School___ Sleep___ Daily Routine___ Recreation___ Other _____

Past Injuries: (including childhood) list major injuries; car/bicycle accidents, any traumas, dates and related symptoms:
_____

Have you recently consulted a physician or any other healthcare professional for this condition? ( ) Yes ( ) No
If so, please provide name and specialty _____

Hospitalization & Surgeries- List all hospitalization and surgeries, (performed or suggested), dates and any current related symptoms. *Please notify us of any pins, wires, prosthesis, canes or any other special equipment* _____
_____

Medication/Supplements (dosage and condition treated): _____

Allergies? Yes____ No____ (If yes, please list) _____

Have you had any X-Rays, CAT scans, MRI's, Blood work done for this issue? ( )Yes ( )No
What were the results? _____

Thank you for choosing our office!
We look forward to helping you achieve greater health and wellness.

OFFICE POLICY

Andres Galego, D.C.
ABH Chiropractics
"American Back Health"
12301 Old Columbia Pike, Suite # 106 Silver Spring MD 20904

We believe that a clear definition of our office policies will allow both you, the patient, and us the doctor, to concentrate on the big issue--- REGAINING AND MAINTAING YOUR HEALTH.

APPOINTMENT POLICY
Multiple appointments have been scheduled, for your convenience, to minimize waiting and to facilitate visits that counts and not the days.

If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within seven days of any cancellation.

This office reserve the right to charge for missed appointments and those cancelled without 24 hours notice.

When entering the office on any given visit, please go directly to the front desk "sign-in". We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointment, please do not hesitate to speak to the receptionist directly.

FINANCIAL POLICY
1. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.

2. All cash payments are expected at the time of service or at the end of each week. Patient's balances may not exceed $200.00 at any time.

3. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service or at the end of each week. Insurance assignment patient's balances may not exceed $200.00 at any time.

4. If you lose your case and/or choose to leave your lawyer, YOU are responsible for your balance.

5. Returned checks and balances over 30 days from service may be subject to additional collection fees.

6. All accounts not paid within 90 days will automatically be put through on your personal credit card.

Type: Visa or MasterCard (please circle one)

Account # _____ Exp. Date: _____

Patient's signature: _____ Date: _____

Patient's address: _____

Home Phone #: _____ Work Phone #: _____

Authorization to Pay Physician

I hereby authorize the_____ , Insurance Company to pay by check made payable and mailed directly to:

Name: Dr. Andres Galego D.C. ABH Chiropractic
Address: 12301 Old Columbia Pike, Suite 106
Silver Spring, MD 20904

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. I hereby designate Dr. Andres Galego,D.C. ABH Chiropractic, as a third party beneficiary to the PIP coverage, med pay, or any other first party benefits that I may be entitled to under the insurance policy with the above name and insurance company. It is my intention that Dr. Andres Galego, D.C. ABH Chiropractic as a third part beneficiary, has the same rights as I would to institute legal proceedings or take other actions to enforce the insurance contract. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said professional Delinquent payment of my balance will be charged at 1.5% monthly interest rate.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this assignment shall be considered as an 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.

Date: _____

_____
Signature of Policy Holder

_____
Signature of Claimant

_____
Signature of Witness