

# Welcome to our office

## Youdeem Chiropractic, Inc.

Dr. Gilbert Youdeem, D.C., CCSP  
9922 Walker St, Suite G  
Cypress, CA 90630  
(714) 527-7463

### 1

#### Please tell us about you!

Today's Date: \_\_\_/\_\_\_/\_\_\_ Driver's License #: \_\_\_\_\_ Male  Female   
Name: \_\_\_\_\_ What do you prefer to be called? \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_  
Email address: \_\_\_\_\_  
Whom can we thank for referring you? \_\_\_\_\_  
Employer: \_\_\_\_\_ How long? \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
Marital Status: Single  Married  Divorced  Separated  Widowed  Spouse's name: \_\_\_\_\_  
Children? No  Yes  How many? \_\_\_\_\_

### 2

#### In event of an emergency

Who should we contact? \_\_\_\_\_ Relationship: \_\_\_\_\_  
Homephone: (\_\_\_\_) \_\_\_\_\_ Workphone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
Who is your Medical Doctor? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
May we contact him/her regarding your condition? Yes  No

### 3

#### Account

Person ultimately responsible for account:  Self  Other ( If other, Please complete below)  
What form of payment would you prefer? cash  check  credit card   
Name \_\_\_\_\_ Relationship: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Workphone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

### 4

#### Previous Chiropractic care

Have you been treated by a Chiropractor before? Yes  No  Date of last visit: \_\_\_\_\_  
Reason for last treatment: \_\_\_\_\_  
How long were you treated? \_\_\_\_\_ Type of treatment given: \_\_\_\_\_

## 5 Reason for your visit?

The reason for this visit is the result of (please circle): work, sports, auto(describe accident below), trauma or chronic.  
Explain what happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 6 More about your visit?

(If Accident Related Skip To Section)

7

Please describe your pain and its location: \_\_\_\_\_  
\_\_\_\_\_

When did the condition begin? \_\_\_/\_\_\_/\_\_\_ Is this condition getting worse? yes  no  constant  comes and goes

Is this condition Interfering with your (please circle): Work, sleep, or dally routine?

If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you had this or simlliar condition in the past? Yes  No  Explain: \_\_\_\_\_  
\_\_\_\_\_

Have you been treated by a Medical Physician for this condition? Yes  No

If yes, where and by whom? \_\_\_\_\_  
\_\_\_\_\_

Type of treatment given: \_\_\_\_\_  
\_\_\_\_\_

## 7 Auto related accident

(If Not Accident Related Skip To Section)

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Date and time of Accident: \_\_\_\_\_ a.m. p.m. (please circle)

Were you the: Driver  Front passenger  Rear passenger  Number of people in accident vehicle: \_\_\_\_\_

If a traffic violation was issued, to whom was it issued? \_\_\_\_\_

Did the police come to the accident site? Yes  No

Was this vehicle equipped with airbags? Yes  No

Was a police report filed? Yes  No

If yes, did it/they inflate? Yes  No

Were there any witnesses? Yes  No

In relation to the base of your skull, where was the headrest?

Were you wearing your seat belt? Yes  No

Above  Below  At base of skull

What did your vehicle impact? Another vehicle  Other  If other, explain: \_\_\_\_\_  
\_\_\_\_\_

Did any part of your body strike anything in the vehicle? Yes  No  If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Make and model of the vehicle you were occupying? \_\_\_\_\_

Name of the location/street on which you were traveling? \_\_\_\_\_  
\_\_\_\_\_

In which direction were you headed? North  South  East  West

What was the approx. speed of your vehicle? \_\_\_\_\_ I was stopped:

Did the impact to your vehicle come from the: Front  Rear  Right side  Left side  Other

During the impact, were you facing: Right  Left  Forward  Were you: Aware  or Surprised by the impact?

If accident vehicle made impact with another vehicle, make & model of that other \_\_\_\_\_  
\_\_\_\_\_

Direction other vehicle was headed? North  South  East  West  Speed of other vehicle? \_\_\_\_\_

8

After injury

Did the accident render you unconscious? Yes  No  If Yes, how long? \_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you gone to a hospital or seen another doctor? Yes  No

When did you go? Just after the accident  The next day  2 days plus

How did you go? Ambulance  or Private transportation

Name of hospital and/or attending doctor: \_\_\_\_\_

\_\_\_\_\_

Was he/she a: D.C.  M.D.  D.O.  D.D.S.

Describe any treatment you received: \_\_\_\_\_

\_\_\_\_\_

Were X-rays taken? [ Y N ] On what body part was X-ray taken? \_\_\_\_\_

By whom? \_\_\_\_\_

Was medication prescribed? [ Y N ] Have you been able to work since this injury? [ Y N ]

Are your work activities restricted as a result of this injury? [ Y N ]

Indicate the symptoms that are a result of this accident:

Is your condition getting worse? [ Y N ] Constant  Comes and goes

Have you retained an attorney? Yes  No

If yes, please give name & phone #: \_\_\_\_\_

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Health history

Are you taking any medications?

	Medication Name:	Dose:	Reason:	Prescribed By:
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____

Have you ever had any of the following disease/medical conditions? Please circle Y for yes or N for no

- |                                   |                              |                                 |                            |
|-----------------------------------|------------------------------|---------------------------------|----------------------------|
| [ Y N ] Heart attack/stroke       | [ Y N ] Fainting             | [ Y N ] Emphysema               | [ Y N ] Heart Murmur       |
| [ Y N ] Congenital Heart Defect   | [ Y N ] Asthma               | [ Y N ] Psychiatric Problems    | [ Y N ] Venereal Disease   |
| [ Y N ] Hepatitis                 | [ Y N ] Lower Back Pain      | [ Y N ] Kidney Problems         | [ Y N ] Shingles           |
| [ Y N ] Cancer / tumor            | [ Y N ] Heart Surg/Pacemaker | [ Y N ] Seizures/Epilipsy       | [ Y N ] Anemia             |
| [ Y N ] Frequent Neck Pain        | [ Y N ] Alcohol/Drug Abuse   | [ Y N ] Diabetes                | [ Y N ] Rheumatic Fever    |
| [ Y N ] Severe Frequent Headaches | [ Y N ] HIV / Aids           | [ Y N ] Artificial Bones/Joints | [ Y N ] Ulcers             |
| [ Y N ] High Blood Pressure       | [ Y N ] Difficulty Breathing | [ Y N ] Spinal Surgery          | [ Y N ] Corticosteroid Use |

Please list any other serious medical condition(s) you have ever had (including surgeries):

Condition:	Date:	Treatment Received:	Treated By:
N/A <input type="checkbox"/>	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____

9

Health history continued

Please list any previous accidents, falls or sports injuries you have ever had:

	Condition:	Date:	Treatment Received:	Treated By:
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____
N/A <input type="checkbox"/>	_____	_____	_____	_____

Please list family health history such as Cancer/Diabetes/High blood pressure/Heart disease/Rheumatoid Arthritis:

\_\_\_\_\_

\_\_\_\_\_

Do you smoke? Yes  No  If Yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol? Yes  No  If Yes, how often? \_\_\_\_\_

For women: Are you taking Birth Control Pills? Yes  No

Are you, or is there a chance you are pregnant? Yes  No  How long? \_\_\_\_\_

10 Please read completely:

I here by authorize assignment of my insurance right and benefits directly to Dr. Gilbert Youdeem, D.C. for services rendered.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize Dr. Gilbert Youdeem, D.C. and his staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney or other health care professional involved in the case.

In the event other responsible parties fail to pay in full for services rendered, I understand I am ultimately and fully responsible for my account. I also understand that I am responsible for my deductible and co-payments at each office visit.

initial: \_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

initial: \_\_\_\_\_

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

initial: \_\_\_\_\_

I agree to the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health or insurance status.

Signature: \_\_\_\_\_ Please print your name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dr. Gilbert Youdeem, D.C  
Certified Chiropractic Sports Physician



9922 Walker St. #G Cypress, CA 90630  
Phone: (714) 527-7463 E- Mail DrYoudeem@aol.com

### Chiropractic Informed Consent To Treat

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as 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, whether signatories to this form or not.

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 procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further 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, dislocations 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 judgment 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 further understand there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 further condition(s) for which I seek treatment.*

Chiropractor's Name: Dr. Gilbert Youdeem, D.C., CCSP

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

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

**Dr. Gilbert Youdeem, D.C**  
Certified Chiropractic Sports Physician  
DrYoudeem@aol.com



9922 Walker St. #G Cypress, CA 90630

Phone: (714) 527-7463 E-Mail

## HIPAA PRIVACY REGULATIONS

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that Youdeem Chiropractic, Inc. (Dr. Gilbert Youdeem, D.C., CCSP) will not reveal to anybody personal information about you or your family member (i.e. name, address, social security number as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation, or fund raising.

It is, however, understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing (paper and wire), include fax transmissions, insurance company follow-up and interaction with billing services relating to patient care
- Hospital workers, nurses, aids, and medical records department
- Emergency officials, Paramedics, fire personnel, emergency room physicians, nurses or technicians. Personal religious designate.
- Our office staff
- Pharmacists, drug program personnel/workers
- Completions of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

My signature below authorizes the release of any necessary information listed above.

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

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

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### Office Policy & Procedures

**Insurance verification - The benefits we have quoted to you are an estimate of your coverage, based on information we received from your insurance company. Your actual coverage is determined when claims are received & processed by your insurance company.**

**Please check your EOB (Explanation of Benefits) for your coverage determination by your insurance company when you receive it.**

**Our office is a zero balance office. All deductibles/copays/co-insurances are due at the time services are rendered.**

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

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date