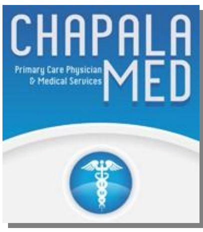


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**EMAIL:**

## PATIENT INFORMATION

Date:_______________________________________________Primary Care Provider: ___________________________________

Patient Name:___________________________________________DOB:_________________Age:_______________________

Address:__________________________________________City, State, Zip:________________________________________

Home Phone#:__________________________Mobile#:__________________________Work#:___________________________

Social Security #:____________________________________ Gender:_______M _______F

Marital Status:______Single _______Married_______Divorced _______Widowed

Type of Insurance: _____Private _____Worker's Comp _____Auto _____Personal _____None

## EMPLOYER INFORMATION

Occupation:______________________________________________________________________________________________

Employer:______________________________________________Phone#:___________________________________________

Address:____________________________________________City, State, Zip:_______________________________________

## HEALTHCARE and MEDICAL WISHES

Emergency Contact(s) Name:_____________________________________Relationship:___________________________________

Tel:_______________________________________________________Tel2:_________________________________________

DO YOU HAVE A LIVING WILL? ____________________________ Do you have a Health care power of attorney?_________________

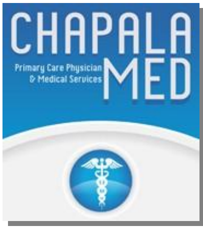
Name of Insurance Company:____________________________________________Policy#:_____________________________

If you answered yes to any of these questions, whom? ________________________________________________________________

Who knows your healthcare and END OF LIFE wishes best?_______________________________________________________________

Who can or who do you wish to make Medical or END OF LIFE decisions for you if you are incapacitated or an emergency situation?________

Name and contact information of the mentioned person(s): NAME(s) /Relationship: ____________________________________________



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## PAGARE
## PROMISE TO PAY

Por este documento ____________________________________________________________________
prometo pagar a la orden de **CHAPALA MED PRECISAMENTE EN LA CIUDAD DE CHAPALA, JALISCO** LA SUMA PRINCIPAL $_______________(_____________________________________________.)
MONEDA DE CURSO LEGAL EN LOS ESTADOS UNIDOS MEXICANOS EL DÍA____DE_____DEL___.

En caso de que el suscriptor no pague en la fecha de su vencimiento la totalidad del importe que deba pagar a **CHAPALA MED** conforme a este PAGARE, el suscriptor pagará, a la vista, intereses moratorios, a razón del cinco por ciento (5%) mensual, calculados desde el día de dicho vencimiento hasta e inclusive la fecha de su pago total.

La suma principal de este PAGARE y los intereses correspondientes al mismo se le pagarán a **CHAPALA MED** en el domicilio ubicado en Libramiento Chapala-Ajijic No. 132 Int. 21 Plaza Interlago C. P. 45922, en la ciudad de Ajijic, Jalisco.

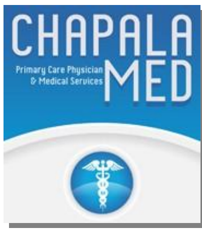
Para todo lo relativo a la interpretación y cumplimiento de este PAGARE, el suscriptor señala y se somete expresamente a la jurisdicción y competencia de los Juzgados y Tribunales del Primer Partido Judicial en la Ciudad de Chapala, Jalisco, renunciando clara y terminantemente a cualquier otro fuero que pudiere corresponderle por razón de su domicilio presente o futuro.

El presente PAGARE consta de una página y se suscribe en la ciudad de Ajijic, Jalisco,________DE___________ DEL________.

**SUSCRIPTOR**

______________________________________________

**Este PAGARE será utilizado solamente en casos de urgencias, tratamientos y procedimientos complejos u hospitalizaciones.**

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## PRIVACY NOTIFICATION
## AVISO DE PRIVACIDAD

**QUIÉNES SOMOS**

Chapala Med **es responsable del tratamiento de sus datos personales, con domicilio en Libramiento Chapala-Ajijic No. 132 Int. 21, C. P. 45922, Ajijic, Jalisco.**

**PARA QUÉ RECABAMOS Y UTLIZAMOS SUS DATOS**

**- Prestación de servicios médicos** (cirugía., estudios diagnósticos, atención de enfermería, tratamientos oncológicos, análisis de laboratorio, radiología e imagen, estudios y análisis patológicos, terapia, rehabilitación, dieta y nutrición y demás fines relacionados con servicios de salud.)

- Creación, estudio, análisis, actualización y conservación del **expediente clínico.**

**- Facturación y cobranza por servicios.**

**- Estudios clínicos, registros, estadísticas y análisis de información de salud.**

**-** Conservación de **registros para seguimiento a servicios,** prestación de servicios en el futuro y en general para dar seguimiento a cualquier relación contractual

- Análisis estadísticos y de mercado.

- **Promoción y mercadeo** de productos y servicios de **Chapala Med** u otras empresas pertenecientes al mismo grupo corporativo

**MÁS INFORMACIÓN**

Si requiere mayor información puede acceder a nuestro aviso de privacidad completo a través de nuestra página web: www.chapalamed.com

________________________________________

NOMBRE Y FIRMA

Insurance Type: _____WORK INJURY _____AUTO _____PRIVATE

Date of Injury:__________________________________________Claim#:______________________________________________

Name of Carrier:_________________________________________________Telephone#:_________________________________

Address:________________________________________________City, State, Zip:_____________________________________

Compensable Body Part:_____________________________________________________________________________________

Adjuster's Name:____________________________________________Telephone#:____________________________________

## ASSIGNMENT AND RELEASE OF BENEFITS

Please understand that we can't, as a third party, become involved in prolonged insurance negotiations. This is your patient responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I authorize the physician to release any medical information including diagnosis, Xrays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: Insurance, Diagnostic, Legal, and at times when the physician deems it necessary in order to ensure the best medical care on my behalf.

I further understand that any person(s) that receive these records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for the release of the information.

I CERTIFY that I have read and fully understand the above and accept financial responsibility in full for this account.

___________________________________________ ______________________________________

Signature of Patient Date

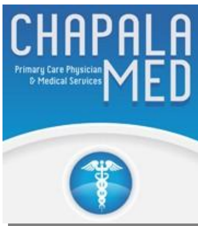
## In case of emergency, please contact:

Name:______________________________________________________

Address:_____________________________________________________________

Phone Number:________________________________

Relationship:_____________________________________



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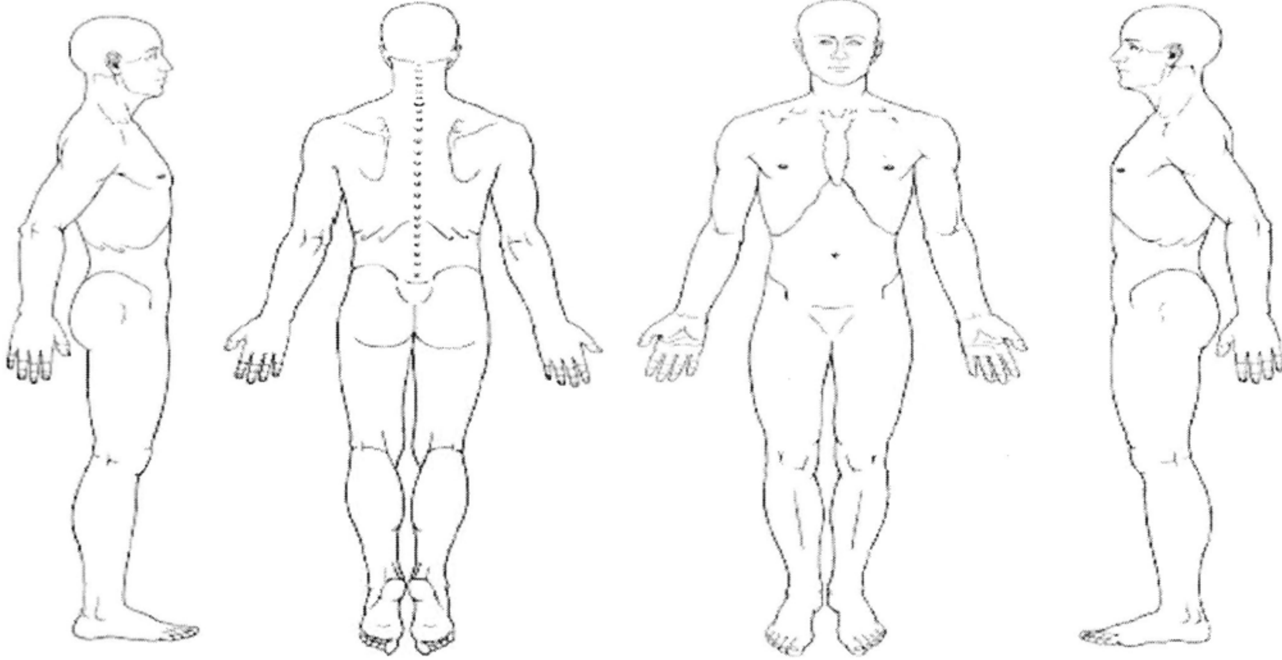
## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN. ALSO MARK (X) FOR NUMBNESS, (T) FOR TINGLING, (B) FOR BURNING.



**PAIN:**
When did the pain begin?

______________________________________________

HOW did it start?

☐ Work Accident ☐ Following surgery ☐ No Trauma ☐ Gradual onset

☐ Home accident ☐ Other accident or injury ☐ Auto accident ☐ Unknown

Duration of Pain
☐ 1-4 weeks ☐ 1-3 months ☐ 3-6 months ☐ Less than 1 yr. ☐ More than 1 yr. ☐ Many years

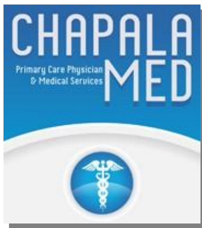
How often does the pain occur?
☐ Continuously ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day) ☐ Less than daily ☐ Weekly ☐ Monthly

Select one or more items below to describe the nature of your pain:
☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/Burning ☐Aching ☐ Stabbing ☐ Tingling ☐ Numbing ☐ Dull ache

How do the following factors affect your pain?

| | Worse | Better | No effect |
|---|---|---|---|
| Standing | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ |
| Sneezing | ☐ | ☐ | ☐ |
| Coughing | ☐ | ☐ | ☐ |
| Weather | ☐ | ☐ | ☐ |
| Lifting | ☐ | ☐ | ☐ |
| Lying Down | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ |

Current Pain Score __________(0-10, 10 being the Worst pain)
Best Pain Score __________
Worst Pain Score __________



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## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

**Check the treatments you have had for pain:**

☐ Acupuncture ☐ Physical Therapy ☐ Biofeedback ☐ Trigger Points ☐ Massage ☐ Hypnosis
☐ Exercise ☐ Psychotherapy ☐ TENS unit ☐ Chiropractor ☐ Brace ☐ Surgery
☐ Facet Blocks ☐ Epidurals ☐ Nerve Blocks ☐ Other

**Imaging Studies/Tests Done:**

☐ MRI ☐ CT Scan ☐ X-rays ☐ EMG/NCV ☐ Results of TEST________________

**PAST MEDICAL HISTORY (circle all that apply)**

Constitutional
Obesity Weight loss Weight gain
Musculoskeletal
Arthritis Fibromyalgia Muscle spasms
Neurological
Headache Seizures Migraines
Stroke
Psychiatric
Depression Substance Abuse Anxiety
Anxiety Bipolar Schizophrenia
Cardiovascular
Angina Heart Attack Heart Stent
Pacemaker High Blood Pressure (Hypertension)
Respiratory
Asthma Emphysema Chronic Bronchitis
Lung Cancer
Gastrointestinal
Reflux Hepatitis Ulcers
Irritable Bowel Syndrome Heartburn
Cirrhosis Diverticulitis Colon Cancer
Genitourinary
Impotence Kidney Stones Incontinence
Endocrine, Hematologic, Allergy/Immunologic, HEENT
Diabetes Hypothyroidism Hyperthyroidism
HIV Hyperlipidemia (Elevated Cholesterol)
Leukemia Lymphoma Multiple Myeloma
Rheumatologic
Lupus Sjogren's Scleroderma
Polymyalgia Rheumatica Rheumatoid Arthritis

**REVIEW OF SYSTEMS (circle all that apply)**

Chills Fever Fatigue
Numbness Weakness
Confusion Dizziness Light Sensitivity
Loss of consciousness
Suicidal thoughts
Difficulty Sleeping
Chest Pain Palpitations
Cough Shortness of Breath
Diarrhea Constipation Abdominal Pain
Bloating Nausea
Vomiting
Decreased Libido Urinary frequency
Easy Bruising Ringing in Ears

**Surgical History:**

Appendectomy _________Tonsillectomy/Adenoids __________Gallbladder surgery ________Coronary Bypass ______________

Hernia Repair __________Tubal Ligation ______Mastectomy _________Hysterectomy ________Breast Biopsy _____________

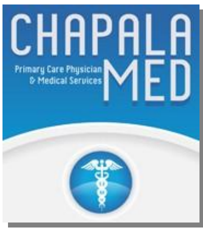
Prostate ________Vasectomy _______Knee Replacement _________Hip Replacement _________Knee Surgery _____________

Shoulder Surgery ___________ Cataracts ___________Colon ________Liver Surgery ________________________________

Back Surgery: ____________________________________________________________________________

Neck Surgery: ____________________________________________________________________________

Other: ________________________________________________________________________________



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## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

WOMEN: ARE YOU PREGNANT? ☐ YES ☐ NO ☐ NOT SURE PATIENT'S INITIALS ____________

**Social History:**

Do you smoke? YES NO How many packs per day? ____________________ How many years? ________________

Do you drink alcohol? YES NO How much per days? ____________________ How many years? ________________

Do you use illicit drugs YES NO How much per days? ____________________How many years? ________________

**FAMILY HISTORY:**

| CONDITIONS | DIABETES | HEART | ANXIETY | KIDNEY | CANCER | DEPRESSION | BACK | OTHER |
|---|---|---|---|---|---|---|---|---|
| MOTHER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| FATHER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BROTHER(S) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SISTER(S) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**ALLERGIES:**

☐ Latex ☐ Iodine/ IV contrast ☐ Betadine ☐ Environmental

Drug ALLERGIES

1. ____________________
2. ____________________
3. ____________________

**List All Medications You Are Currently Taking:**

| | Medication | Dose | | Medication | Dose |
|---|---|---|---|---|---|
| **1.** | | | **9.** | | |
| **2.** | | | **10.** | | |
| **3.** | | | **11.** | | |
| **4.** | | | **12.** | | |
| **5.** | | | **13.** | | |
| **6.** | | | **14.** | | |
| **7.** | | | **15.** | | |
| **8.** | | | **16.** | | |

**Past pain medications tried:** ________________________________________________

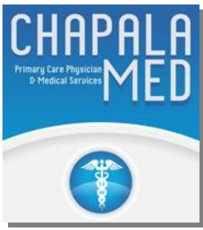
________________________________________________________________________

________________________________________________________________________

**I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONAIRE ACCURATELLY AND TO THE BEST OF MY KNOWLEDGE.**

______________________________ ______________________

**PATIENT OR LEGAL GUARDIAN SIGNATURE** **DATE**



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By signing this form, I ______________________________, authorize the use and disclosure of my health information as described below:

1. You can disclose my health information as described below:
   - ❑ leave messages on my answering machine
   - ❑ leave messages with my spouse
   - ❑ leave messages with anyone who answers phone

2. You can leave message confirming appointments as described below:
   - ❑ leave messages on my answering machine
   - ❑ leave messages with my spouse
   - ❑ leave messages with anyone who answers phone

Name of person/persons authorized to receive this information: ______________________________

______________________________________________________________

______________________________________________________________

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or insurance policy. I understand that uses or disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to

Libramiento Chapala-Ajijic No. 132 Int. 21 Plaza Interlago, Ajijic,
Jalisco 45922

Signature of Patient ______________________________ Date ______________

Print Name of Patient ______________________________________________