

**DAVID E. TEITELBAUM, D.O., P.A.**  
**ACUPUNCTURE PROLOTHERAPY OSTEOPATHIC MANIPULATION**  
**BIOIDENTICAL HORMONE REPLACEMENT THERAPY**

4455 Camp Bowie Blvd #214  
Fort Worth, Texas 76107

Phone: (817) 335-4220  
Fax: (817) 335-3171

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

Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Phone at which you would like to receive appointment reminders: \_\_\_\_\_

The only insurance we accept is Medicare. Do you have Medicare? Y / N

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Driver's Lic #: \_\_\_\_\_

Sex: M / F Marital Status: S M D W

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Family Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party for Billing: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If insurance is in your spouse's name: Name: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive our free monthly E-newsletter? Y / N

I hereby authorize David E. Teitelbaum, D.O. to release any information acquired in the course of my examination and treatment.

I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to include xray reports or films to David E. Teitelbaum, D.O.

I hereby authorize David E. Teitelbaum, D.O. to receive the payment directly for the surgical and medical benefits, if any, otherwise payable under the terms of my insurance contract/policy.

I hereby authorize photocopies of this form to be as valid as the originals.

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Patient Signature

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Date

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Authorized Signature

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Date



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Please list any treatments (including home remedies) and surgeries that you have tried so far. Indicate if they have helped, had no effect on, or worsened your condition.

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Describe any disability that has resulted from your main complaints relative to your work, social life, home life or leisure activities.

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Have you had Xrays, MRI, etc.? Yes / No  
When? \_\_\_\_\_ Where? \_\_\_\_\_

Please list all medications you are currently taking and the reasons for taking them. Include vitamins, aspirin, Tylenol, birth control, laxatives, antacids, etc.

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Please list all allergies: \_\_\_\_\_  
\_\_\_\_\_

Please list all surgeries with dates:

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After careful consideration, please check all of the following that apply to you:

**I.**

**Symptoms:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Eye or vision problems                             | <input type="checkbox"/> Nervous, irritable, short tempered | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Sensitive to bright light, sound, wind, odors      | <input type="checkbox"/> Headaches                          | <input type="checkbox"/> Cold hands and feet |
| <input type="checkbox"/> Tension or pain in shoulders, neck, and upper back | <input type="checkbox"/> Migraines                          |  |
|   | <input type="checkbox"/> Weak or brittle nails              |  |

**Traits:**

- |  |  |
|--|--|
| <input type="checkbox"/> Feel confident, act assertively                   | <input type="checkbox"/> Enjoy being first, best, unique, even outlandish  |
| <input type="checkbox"/> Ambitious and enjoy being competitive             | <input type="checkbox"/> Comfortable directing or leading others           |
| <input type="checkbox"/> Openly discuss my abilities and achievements      | <input type="checkbox"/> Follow my own hunches                             |
| <input type="checkbox"/> Comfortable with challenges, conflict or pressure | <input type="checkbox"/> Feel right, even if others disagree or disapprove |

**II.**

**Symptoms:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anxiety, nervousness, or dread | <input type="checkbox"/> Restless and excitable            | <input type="checkbox"/> Easy blushing                 |
| <input type="checkbox"/> Sensitive to heat and cold     | <input type="checkbox"/> Crave cool drinks and spicy foods | <input type="checkbox"/> Burning sensations            |
| <input type="checkbox"/> Hot flashes                    | <input type="checkbox"/> Sores of mouth and tongue         | <input type="checkbox"/> Heart or circulation problems |

**Traits:**

- |   |   |
|---|---|
| <input type="checkbox"/> Enjoy the pleasure my senses                   | <input type="checkbox"/> Get involved easily, enjoy being moved emotionally |
| <input type="checkbox"/> Easily know what another thinks and feels      | <input type="checkbox"/> Optimistic and hopeful despite what others may say |
| <input type="checkbox"/> Enjoy physical contact and emotional intimacy  | <input type="checkbox"/> Easily show affection, enthusiasm and excitement   |
| <input type="checkbox"/> Enjoy excitement and stimulation               |   |
| <input type="checkbox"/> Easily share my innermost feelings and desires |   |

**III.**

**Symptoms:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Difficult bowel movements     | <input type="checkbox"/> Water retention, puffiness        | <input type="checkbox"/> Ulcers  |
| <input type="checkbox"/> Slow digestion or indigestion | <input type="checkbox"/> Difficulty focusing, distractible | <input type="checkbox"/> Sensation of heaviness in the head, body, and limbs |
| <input type="checkbox"/> Loose stool or diarrhea       | <input type="checkbox"/> Irritable Bowel                   |  |
| <input type="checkbox"/> Frequent gas or bloating      |  |  |

**Traits:**

- Agreeable and accommodating
- Nurturing and supportive, putting others needs first
- Enjoy frequent socializing with friends and family
- Enjoy being relied upon for reassurance and help

- Involved in other people's lives
- Like to create a comfortable environment for others
- Loyal and accessible to friends, family, and co-workers
- Like getting close and being needed

#### **IV.**

##### **Symptoms:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Coughing, sneezing                               | <input type="checkbox"/> Frequent phlegm                               | <input type="checkbox"/> Dryness or tightness of mucous membranes or skin |
| <input type="checkbox"/> Respiratory allergies                            | <input type="checkbox"/> Shortness of breath or wheezing from exertion | <input type="checkbox"/> Skin rashes, eczema, or hives                    |
| <input type="checkbox"/> Runny nose or stuffy sinuses                     | <input type="checkbox"/> Asthma  | <input type="checkbox"/> Skin growths, acne                               |
| <input type="checkbox"/> Frequent or lingering colds, coughs, sore throat | <input type="checkbox"/> Bronchitis                                    |   |
| <input type="checkbox"/> Thyroid problems                                 |  |   |

##### **Traits:**

- |   |  |
|---|--|
| <input type="checkbox"/> Prefer a neat and orderly lifestyle                    | <input type="checkbox"/> Willing to accept the authority of those with more competence |
| <input type="checkbox"/> Committed to high moral principles and conduct         | <input type="checkbox"/> Enjoy solving puzzles and mysteries                           |
| <input type="checkbox"/> Meticulous, tasteful and discriminating                | <input type="checkbox"/> Virtue and principle before pleasure and fulfillment          |
| <input type="checkbox"/> Self-contained, not overly involved in others' affairs | <input type="checkbox"/> Like things to run calmly and smoothly                        |

#### **V.**

##### **Symptoms:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ear or hearing problems         | <input type="checkbox"/> Kidney or bladder problems, infections | <input type="checkbox"/> Lack of stamina and endurance |
| <input type="checkbox"/> Dark rings under eyes           | <input type="checkbox"/> Stiffness of spine and joints          | <input type="checkbox"/> Need to sleep a lot           |
| <input type="checkbox"/> Diminished libido               | <input type="checkbox"/> Recurring low back pain                | <input type="checkbox"/> Apathy, low motivation        |
| <input type="checkbox"/> Frequent or difficult urination | <input type="checkbox"/> Hair loss or premature graying         | <input type="checkbox"/> Mental dullness               |

##### **Traits:**

- |   |  |
|---|--|
| <input type="checkbox"/> Cautious and sensible                                  | <input type="checkbox"/> Excited by intellectual pursuits            |
| <input type="checkbox"/> Particularly enjoy solitude                            | <input type="checkbox"/> Careful about what I reveal to other people |
| <input type="checkbox"/> Tend to keep feelings, thoughts and opinions to myself | <input type="checkbox"/> Preferably self-sufficient and independent  |
| <input type="checkbox"/> Don't mind being considered unusual or eccentric       | <input type="checkbox"/> Cherishing privacy and a few good friends   |

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

NAME: \_\_\_\_\_

# PAIN DRAWING GRID ASSESSMENT

Draw the location of your pain on the body outlines and mark how bad it is on the pain line at the bottom of the page.

ACHE

////

///

BURNING

BBB

BBB

NUMBNESS

XXXX

XX

PINS & NEEDLES

= = =

= = =

STABBING

ZZZ

ZZZ

OTHER

OOOO

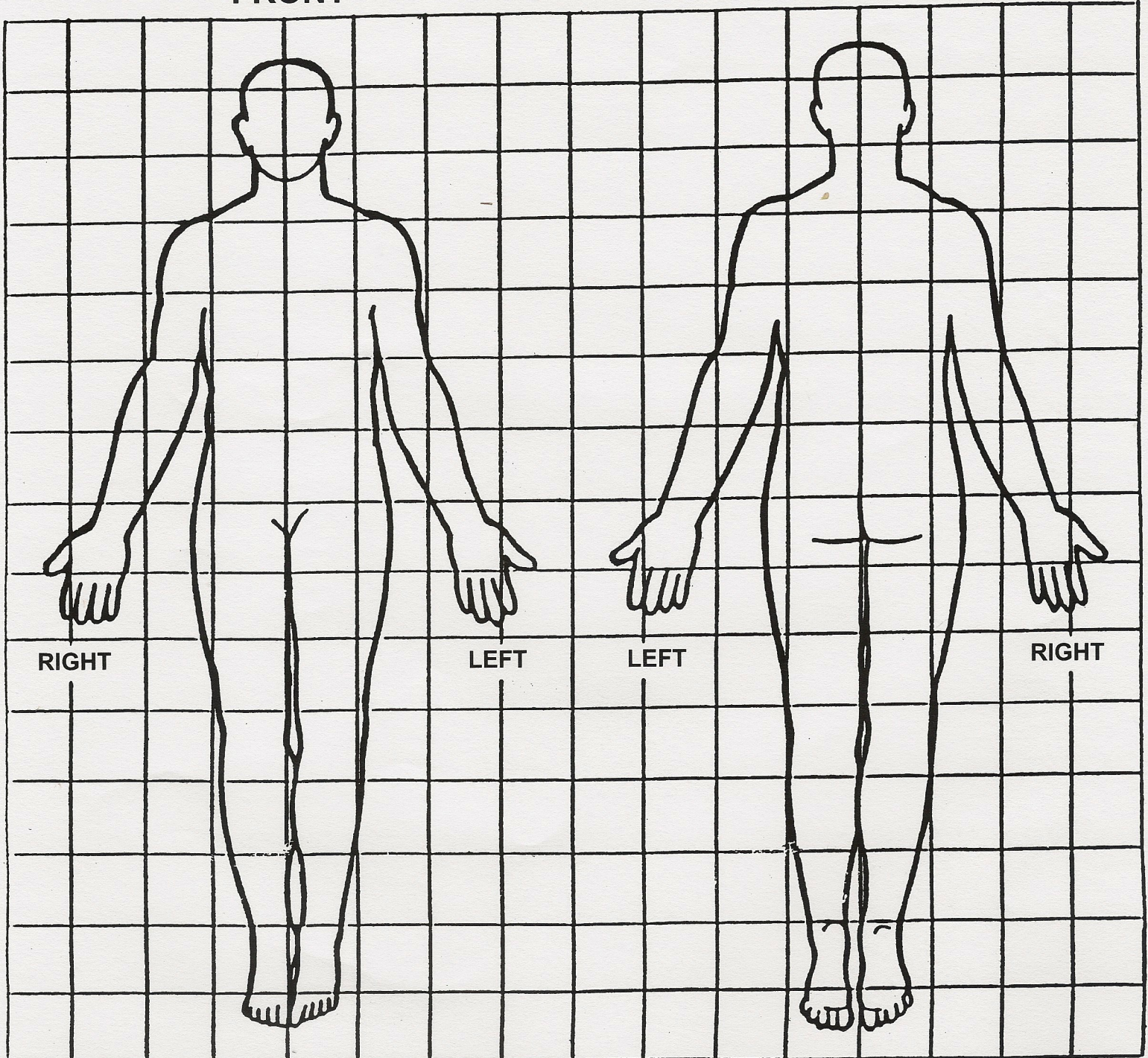
OOOO

Percentage of pain in back \_\_\_\_\_

Percentage of pain in legs \_\_\_\_\_

FRONT

BACK



NO PAIN

1 2 3 4 5 6 7 8 9 10

INTOLERABLE PAIN

(CIRCLE YOUR PAIN ESTIMATE)

**CAMP**

Describe any other serious illnesses you have had in the past 2 years not already listed with your main complaints:

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Do you have any worries (legal, financial, personal) that might be affecting your health?

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Do you have a source of spiritual strength that you turn to in times of trouble?

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Do you exercise regularly? Yes / No How? How often?

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Do you sleep well? Yes / No Do you awaken refreshed? Yes / No

Do you have a history of drug, alcohol, or substance abuse? Yes / No Describe:

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Do you drink alcoholic beverages? Yes / No Amount per week: \_\_\_\_\_

Number of sodas per week: Diet \_\_\_\_ Regular \_\_\_\_

Do you now, or have you ever smoked? Yes / No How many years? \_\_\_\_\_

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**OSTEOPATHIC MANIPULATION   ACUPUNCTURE   PROLOTHERAPY**

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**OUR OFFICE POLICIES**

Please complete and sign all of our forms and bring them with you to your appointment. We would appreciate your arrival 20 minutes prior to your appointment to give us sufficient time to process all of your information.

**INSURANCE:**

NOTE: Our office does not file insurance on group or private plans. We do, however, provide you with a superbill which you may use to file for reimbursement with your insurance carrier.

NOTE: We do accept and file Medicare claims and Medicare secondary insurances only. Remember to bring your Medicare card and your Medicare supplemental insurance cards. If you have Medicare, it is your responsibility to pay for any deductible amount, co-insurance, non-covered services, or any other balance not paid by your insurance company.

To keep our fees as low as possible, it is our policy to collect for services at the end of each appointment, unless you have Medicare. For your convenience, we accept payment by Mastercard, Visa, and Discover, American Express and personal checks. We do not accept post-dated checks.

Medical insurance usually reimburses well for office visits and Osteopathic manipulative treatments. Reimbursement for Acupuncture, Prolotherapy, and Spinal Decompression varies widely.

**MISSED APPOINTMENTS:**

Please recognize that an appointment cancelled at the last minute results in a lost opportunity for another patient to see us. We therefore require 24 hours advanced notice for cancellation. Patients who do not cancel an appointment 24 hours in advance will be billed for the entire amount of that appointment. Exceptions will be made for emergency situations.

I have read the above and understand Dr. Teitelbaum's office policies.

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

# Required Addendum to our NPP (Notice of Privacy Practices)

Effective as of February 15, 2026

**David Teitelbaum, D.O., P.A.**

## **Special Privacy Protections for Certain Health Information**

We are **not primarily a substance use disorder (SUD) treatment program**. We may receive and maintain **SUD-related information incidentally** (e.g., referrals, history, meds, labs) and that information we maintain may be subject to additional federal privacy protections, including records related to the diagnosis, treatment, or referral for treatment of a substance use disorder. These records are protected by federal law (42 C.F.R. Part 2), which, in some cases, is more restrictive than HIPAA. When these stricter rules apply, we follow them.

## **How We May Use and Disclose Health Information**

We may use and disclose your health information for treatment, payment, and health care operations. When information includes substance use disorder records, additional legal requirements may apply, including your written consent before using or disclosing that information.

## **Limits on Use of Substance Use Disorder Records**

Federal law places **strict limits** on how substance use disorder records may be used or disclosed. Substance use disorder records cannot be used or disclosed to initiate or substantiate civil, criminal, administrative, or legislative proceedings without written consent or a qualifying court order.

## **Authorization and Consent**

Certain uses and disclosures require written authorization. You may revoke authorization at any time by written request, except where already relied upon. If your health information includes substance use disorder records, your authorization may allow us to use and disclose that information for **treatment, payment, and health care operations**, as permitted by law.

## **Your Rights Regarding Your Health Information**

You have rights to inspect, access, amend, request restrictions, request confidential communications, and receive an accounting of disclosures, as permitted by law.

## **Redisclosure Notice**

If your health information is disclosed to another party, that party may be permitted to **redisclose** the information, and it may no longer be protected by HIPAA. However, **substance use disorder records** may continue to be protected by federal law even after disclosure, depending on the circumstances.

## **Public Health and De-Identified Information**

We may disclose **de-identified health information** for public health, research, or health care operations purposes as permitted by law. De-identified information does not identify you and cannot reasonably be used to identify you.

## **Fundraising Communications**

We may contact you for **fundraising purposes**. You have the right to **opt out** of receiving fundraising communications at any time. Your decision to opt out will **not affect your access to care**.

## **Complaints and Enforcement**

If you believe your privacy rights have been violated, you may file a complaint with us or with the **U.S. Department of Health and Human Services**. You will not be retaliated against for filing a complaint.

## **Changes to This Notice**

We reserve the right to change this Notice of Privacy Practices at any time. Any changes will apply to all health information we maintain. The current version of this Notice will be available upon request and on our website.

Signed: \_\_\_\_\_

Provided By HCSI

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