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

_____ _____

Patient Signature Date

_____ _____

Authorized Signature Date

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Welcome to our practice! Please answer all of the following questions to help us serve you more efficiently.

NAME: _____ DATE: _____

Please describe each of your main complaints. Include date of onset and what has happened since that time. (Continue on the back of this page if needed.)

If any of your main complaints are work related, auto accident related or injury related, please describe in detail how the accident happened, giving dates, times and events.

_____
_____

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.

_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____

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.

_____
_____
_____
_____
_____
_____

Please list all allergies: _____
_____

Please list all surgeries with dates:

_____

_____

_____

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

I.

Symptoms:

__ Eye or vision problems
__ Sensitive to bright light, sound, wind, odors
__ Tension or pain in shoulders, neck, and upper back
__ Nervous, irritable, short tempered
__ Headaches
__ Migraines
__ Weak or brittle nails
__ Difficulty sleeping
__ Cold hands and feet

Traits:

__ Feel confident, act assertively
__ Ambitious and enjoy being competitive
__ Openly discuss my abilities and achievements
__ Comfortable with challenges, conflict or pressure
__ Enjoy being first, best, unique, even outlandish
__ Comfortable directing or leading others
__ Follow my own hunches
__ Feel right, even if others disagree or disapprove

II.

Symptoms:

__ Anxiety, nervousness, or dread
__ Sensitive to heat and cold
__ Hot flashes
__ Restless and excitable
__ Crave cool drinks and spicy foods
__ Sores of mouth and tongue
__ Easy blushing
__ Burning sensations
__ Heart or circulation problems

Traits:

__ Enjoy the pleasure my senses
__ Easily know what another thinks and feels
__ Enjoy physical contact and emotional intimacy
__ Enjoy excitement and stimulation
__ Easily share my innermost feelings and desires
__ Get involved easily, enjoy being moved emotionally
__ Optimistic and hopeful despite what others may say
__ Easily show affection, enthusiasm and excitement

III.

Symptoms:

__ Difficult bowel movements
__ Slow digestion or indigestion
__ Loose stool or diarrhea
__ Frequent gas or bloating
__ Water retention, puffiness
__ Difficulty focusing, distractible
__ Irritable Bowel
__ Ulcers
__ Sensation of heaviness in the head, body, and limbs

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:

__ Coughing, sneezing
__ Respiratory allergies
__ Runny nose or stuffy sinuses
__ Frequent or lingering colds, coughs, sore throat
__ Thyroid problems
__ Frequent phlegm
__ Shortness of breath or wheezing from exertion
__ Asthma
__ Bronchitis
__ Dryness or tightness of mucous membranes or skin
__ Skin rashes, eczema, or hives
__ Skin growths, acne

Traits:

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

V.

Symptoms:

__ Ear or hearing problems
__ Dark rings under eyes
__ Diminished libido
__ Frequent or difficult urination
__ Kidney or bladder problems, infections
__ Stiffness of spine and joints
__ Recurring low back pain
__ Hair loss or premature graying
__ Lack of stamina and endurance
__ Need to sleep a lot
__ Apathy, low motivation
__ Mental dullness

Traits:

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

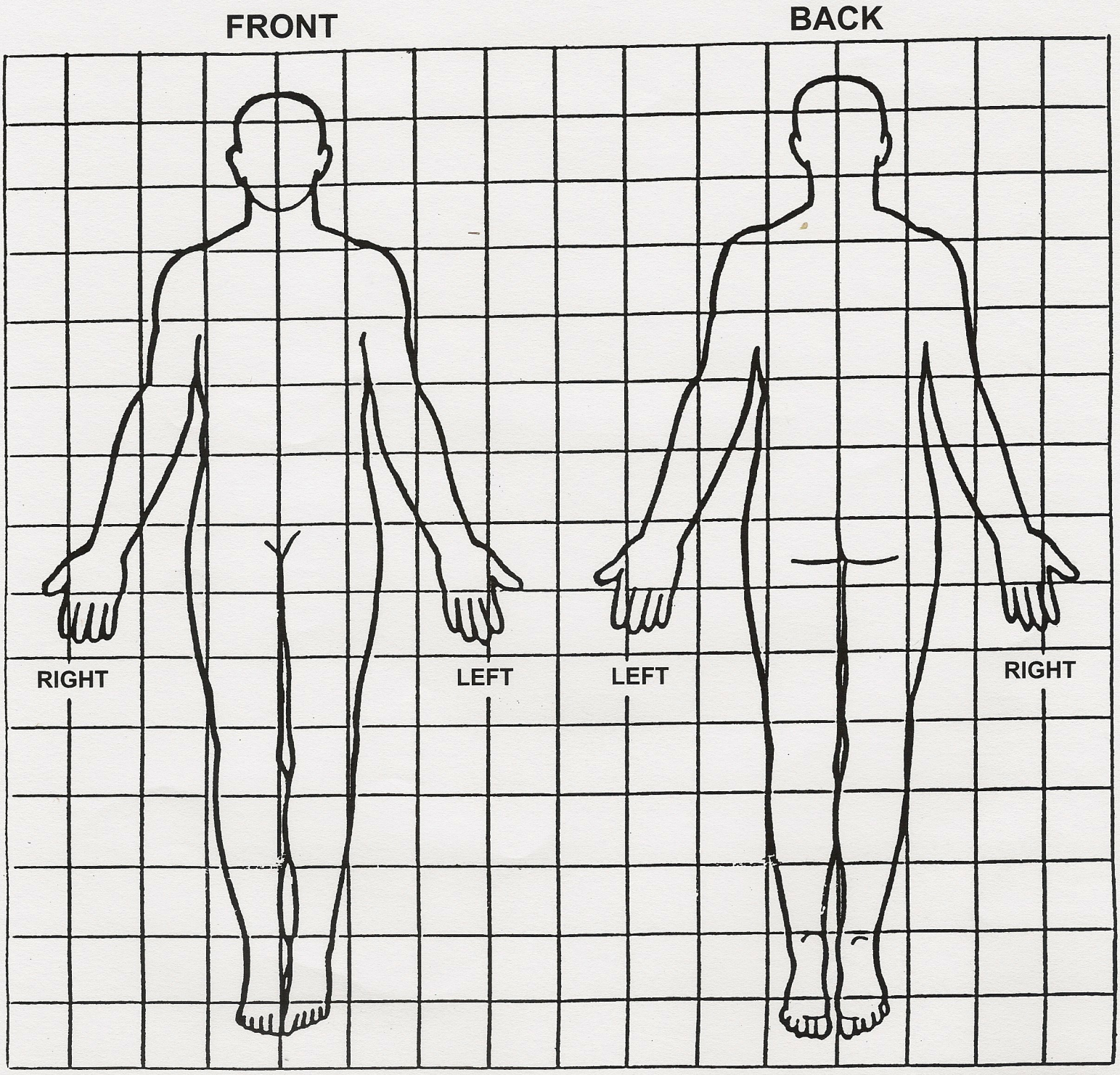
DATE: _____ NAME: _____

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	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
////	B B B	X X X X	= = =	Z Z Z	O O O O
///	B B B	X X	= = =	Z Z Z	O O O O

Percentage of pain in back _____ Percentage of pain in legs _____



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:

_____

_____

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

_____

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

_____

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

_____

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:

_____

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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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: _____