

DAVID E. TEITELBAUM, D.O., P.A.

ACUPUNCTURE PROLOTHERAPY OSTEOPATHIC MANIPULATION

4455 Camp Bowie Blvd #214
Fort Worth, Texas 76107

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

Name: _____ Phone(s): _____

Phone at which you would like to receive appointment reminders: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SS#: _____ Driver's Lic #: _____

Who referred you? _____ Family Physician: _____

Sex: M / F Marital Status: S M D W Do you have Medicare? Y / N

Occupation: _____ Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Work phone: _____

Emergency Contact: _____ Phone: _____

Responsible Party for Billing: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

If insurance is in your spouse's name: Name: _____

SS#: _____ Work phone and address: _____

Dr. Teitelbaum often has medical students training under him. If you would prefer **not** to have a medical student present during your visit, please check here: _____

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.

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:

- | | | |
|---|---|--|
| <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:

- | | |
|---|--|
| <input type="checkbox"/> Agreeable and accommodating | <input type="checkbox"/> Involved in other people's lives |
| <input type="checkbox"/> Nurturing and supportive, putting others needs first | <input type="checkbox"/> Like to create a comfortable environment for others |
| <input type="checkbox"/> Enjoy frequent socializing with friends and family | <input type="checkbox"/> Loyal and accessible to friends, family, and co-workers |
| <input type="checkbox"/> Enjoy being relied upon for reassurance and help | <input type="checkbox"/> 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 |

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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OSTEOPATHIC MANIPULATION ACUPUNCTURE PROLOTHERAPY

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Policies, Insurance, and Fees

Medicare: We do accept Medicare, and will file this for you. We will also file with your secondary insurance. We are not contracted with any Medicare HMO's, however. If you are not sure whether or not your Medicare provider is an HMO, please inquire before your visit. It is your responsibility to pay your yearly Medicare deductible, or for any non-covered services.

Private and Group Insurance: We do not file insurance on any group or private plans other than Medicare. However, we do provide you with a superbill so that you can file on your own. This is not difficult, and most insurances will reimburse a significant percentage of our fee.

It is our policy to collect for services at the end of each appointment. For your convenience, we accept Mastercard, Visa, Discover, American Express, and personal checks.

Missed Appointments: Please recognize that we provide longer office visits than the average physician. 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 agree to Dr. Teitelbaum's office policies.

Signed: _____

Date: _____