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| Seguro Medico. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Grupo# | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | ID # | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Nombre Asegurado | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Fecha de Nacimiento | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | SS # | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lugar de Empleo Asegurado Principal | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | #Trabajo | (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Relacion con Asegurado Principal | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Referido | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Lugar de trabajo | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Posicion | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Direccion | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | #Trabajo | (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PACIENTE NUEVO
RECORD DE SALUD CONFIDENCIAL**

# Casa ( \_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Trabajo ( \_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ #Cel ( \_\_\_ ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Apellido\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nombre \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Direccion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ciudad \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado \_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_

Edad \_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado Civil S C D V Sexo M F SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nombre Esposo(a) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_





**Marque areas dolorosas o sensacion anormal**

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|  | **Cuando comenzaron los sintomas?** |  |
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|  | **Como comenzaron los sintomas?** |  |
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| \_\_\_ | Cabeza | \_\_\_I \_\_\_D | Hombro |
| \_\_\_ | Cuello | \_\_\_I \_\_\_D | Codo |
| \_\_\_ | Espalda Alta | \_\_\_I \_\_\_D | Manos |
| \_\_\_ | Esp. Media | \_\_\_I \_\_\_D | Cadera |
| \_\_\_ | Espalda Baja | \_\_\_I \_\_\_D | Rodilla |
| \_\_\_ | Pelvico | \_\_\_I \_\_\_D | Pie |

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| **Circule en la escala su nivel de dolor:** |
| 0 1 2 3 4 5 6 7 8 9 10 |

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| **Describa sus sintomas:** |
| \_\_\_ | Agudo | \_\_\_ | Punzado |
| \_\_\_ | Aburrido | \_\_\_ | Ardor |
| \_\_\_ | Adormecimiento | \_\_\_ | Hormigueo |

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| **Frecuencia?** | **(% del dia):** |
| \_\_\_ | Constante | (76-100%) |
| \_\_\_ | Frecuente | (51-75%) |
| \_\_\_ | Intermitente | (26-50%) |
| \_\_\_ | Ocasional | (0-25%) |

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| **Que empeora su condicion ?** |
| \_\_\_ | Pararse | \_\_ | Caminar | \_\_\_ | Sentado |
| \_\_\_ | Acostado | \_\_ | Toser | \_\_\_ | Cargar |

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| **Que alivia su condicion?** |
| \_\_\_ | Descanso | \_\_ | Hielo | \_\_\_ | Calor |
| \_\_\_ | Actividad |  | Medicina | \_\_\_\_\_\_\_\_\_ |

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| **Condicion se siente mejor:** |
| \_\_\_ | Manana | \_\_\_ | Mediodia | \_\_ | Noche |

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| **Condicion se siente peor:** |
| \_\_\_ | Manana | \_\_\_ | Mediodia | \_\_ | Noche |

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|  **1. Condicion PRIMARIA:** |

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| **(Seleccione sola UNA)** |

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| \_\_\_ | Cabeza | \_\_\_I \_\_\_D | Hombro |
| \_\_\_ | Cuello | \_\_\_I \_\_\_D | Codo |
| \_\_\_ | Espalda Alta | \_\_\_I \_\_\_D | Manos |
| \_\_\_ | Esp. Media | \_\_\_I \_\_\_D | Cadera |
| \_\_\_ | Espalda Baja | \_\_\_I \_\_\_D | Rodilla |
| \_\_\_ | Pelvico | \_\_\_I \_\_\_D | Pie |

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| **Circule en la escala su nivel de dolor:** |
| 0 1 2 3 4 5 6 7 8 9 10 |

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| **Describa sus sintomas:** |
| \_\_\_ | Profundo | \_\_\_ | Punzado |
| \_\_\_ | Aburrido | \_\_\_ | Ardor |
| \_\_\_ | Adormecido | \_\_\_ | Hormigueo |

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| **Frecuencia?** | **(% del dia):** |
| \_\_\_ | Constante | (76-100%) |
| \_\_\_ | Frecuente | (51-75%) |
| \_\_\_ | Intermitente | (26-50%) |
| \_\_\_ | Ocasional | (0-25%) |

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| **Que empeora su condicion ?** |
| \_\_\_ | Pararse | \_\_ | Caminar | \_\_\_ | Sentado |
| \_\_\_ | Acostado | \_\_ | Toser | \_\_\_ | Cargar |

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| **Que alivia su condicion?** |
| \_\_\_ | Descanso | \_\_ | Hielo | \_\_\_ | Calor |
| \_\_\_ | Actividad |  | Medicina | \_\_\_\_\_\_\_\_\_ |

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| **Condicion se siente mejor:** |
| \_\_\_ | Manana | \_\_\_ | Mediodia | \_\_ | Noche |

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| **Condicion se siente peor:** |
| \_\_\_ | Manana | \_\_\_ | Mediodia | \_\_ | Noche |

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|  **3. Condicion ADICIONAL:** |

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| \_\_\_ | Cabeza | \_\_\_I \_\_\_D | Hombro |
| \_\_\_ | Cuello | \_\_\_I \_\_\_D | Codo |
| \_\_\_ | Espalda Alta | \_\_\_I \_\_\_D | Manos |
| \_\_\_ | Esp. Media | \_\_\_I \_\_\_D | Cadera |
| \_\_\_ | Espalda Baja | \_\_\_I \_\_\_D | Rodilla |
| \_\_\_ | Pelvico | \_\_\_I \_\_\_D | Pie |

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| **Circule en la escala su nivel de dolor:** |
| 0 1 2 3 4 5 6 7 8 9 10 |

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| --- |
| **Describa sus sintomas:** |
| \_\_\_ | Profundo | \_\_\_ | Punzado |
| \_\_\_ | Aburrido | \_\_\_ | Ardor |
| \_\_\_ | Adormecido | \_\_\_ | Hormigueo |

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| **Frecuencia?** | **(% del dia):** |
| \_\_\_ | Constante | (76-100%) |
| \_\_\_ | Frecuente | (51-75%) |
| \_\_\_ | Intermitente | (26-50%) |
| \_\_\_ | Ocasional | (0-25%) |

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| **Que empeora su condicion ?** |
| \_\_\_ | Pararse | \_\_ | Caminar | \_\_\_ | Sentado |
| \_\_\_ | Acostado | \_\_ | Toser | \_\_\_ | Cargar |

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| **Que alivia su condicion?** |
| \_\_\_ | Descanso | \_\_ | Hielo | \_\_\_ | Calor |
| \_\_\_ | Actividad |  | Medicina | \_\_\_\_\_\_\_\_\_ |

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| **Condicion se siente mejor:** |
| \_\_\_ | Manana | \_\_\_ | Mediodia | \_\_ | Noche |

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| **Condicion se siente peor:** |
| \_\_\_ | Manana | \_\_\_ | Mediodia | \_\_ | Noche |

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|  **2. Condicion SECUNDARIA:** |

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| **(Seleccione sola UNA)** |

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| Has visto algun medico para sus sintomas? | \_\_\_ | No |  | \_\_\_ | Si | Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Que estudio o examen ha tenido para su diagnostico ? | \_\_\_ | No |  | \_\_\_ | Si | Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Toma medicamentos para esta condicion? | \_\_\_ | No |  | \_\_\_ | Si | Cual\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has perdido tiempo de trabajo por esta condicion? | \_\_\_ | No |  | \_\_\_ | Si | Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has tenido sintomas SIMILARES en el pasado? | \_\_\_ | No |  | \_\_\_ | Si | Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ha recibido tratamiento quiropractico? | \_\_\_ | No |  | \_\_\_ | Si | Fecha\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Esta embarazada? | \_\_\_ | No |  | \_\_\_ | Si |  |
| Toma medicamentos anticonceptivos? | \_\_\_ | No |  | \_\_\_ | Si |  |
| Visita su ginecologo/obstetra regularmente? | \_\_\_ | No |  | \_\_\_ | Si | Nombre\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Historial Medico:** | \_\_ | Cancer/Tumores | \_\_ | Infeccion/Fiebre | \_\_ | Cardiovascular | \_\_ | Anemia | \_\_ | Artritis |
|  | \_\_ | Ataques | \_\_ | Neurologico | \_\_ | Auto Imunologico | \_\_ | Osteoporosis | \_\_ | Tiroides |
|  | \_\_ | Diabetes | \_\_ | Alta presion | \_\_ | Mareos | \_\_ | Insomnia | \_\_ | Problema Digestivo |
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| **Historial de Abuelos:** | \_\_ | Cancer/Tumores | \_\_ | Infeccion/Fiebre | \_\_ | Cardiovascular | \_\_ | Anemia | \_\_ | Artritis |
|  | \_\_ | Ataques | \_\_ | Neurologico | \_\_ | Auto Imunologico | \_\_ | Osteoporosis | \_\_ | Tiroides |
|  | \_\_ | Diabetes | \_\_ | Alta presion | \_\_ | Mareos | \_\_ | Insomnia | \_\_ | Problema Digestivo |
|  |  |  |  |  |  |  |  |  |  |  |
| **Historial de Padres:** | \_\_ | Cancer/Tumores | \_\_ | Infeccion/Fiebre | \_\_ | Cardiovascular | \_\_ | Anemia | \_\_ | Artritis |
|  | \_\_ | Ataques | \_\_ | Neurologico | \_\_ | Auto Imunologico | \_\_ | Osteoporosis | \_\_ | Tiroides |
|  | \_\_ | Diabetes | \_\_ | Alta presion | \_\_ | Mareos | \_\_ | Insomnia | \_\_ | Problema Digestivo |
|  |  |  |  |  |  |  |  |  |  |  |
| **Historial de Hermanos:** | \_\_ | Cancer/Tumores | \_\_ | Infeccion/Fiebre | \_\_ | Cardiovascular | \_\_ | Anemia | \_\_ | Artritis |
|  | \_\_ | Ataques | \_\_ | Neurologico | \_\_ | Auto Imunologico | \_\_ | Osteoporosis | \_\_ | Tiroides |
|  | \_\_ | Diabetes | \_\_ | Alta presion | \_\_ | Mareos | \_\_ | Insomnia | \_\_ | Problema Digestivo |

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| **Medicamentos:** | **Nombre y Dosis** |  | **Nombre y Dosis** |  | **Nombre y Dosis** |
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| **HIstorial Social:** | \_\_ | Nunca ha fumado | \_\_ | Antes fumaba | \_\_ | Fuma a diario |  |  |  |  |
|  | \_\_ | No usa alcohol | \_\_ | Toma alcohol | \_\_ | Uso de drogas recreacionales |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Alergias:** | \_\_ | Respiratorias | \_\_ | Comida/ Digestion | \_\_ | Piel |  |  |  |  |
|  | \_\_ |  Medicinas (Nombre)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |
| **Cirugias/Hospitalizacion:** | Tipo/area\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cirujano\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cuando?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Tipo/area\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cirujano \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cuando?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Tipo/area \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cirujano \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cuando?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| **En general, mi salud es:** | \_\_ | Excelente | \_\_ | Muy buena | \_\_ | Buena | \_\_ | Regular | \_\_ | Pobre |
| **En comparacion con el pasado año, su salud es:** | \_\_ | Excelente | \_\_ | Muy buena | \_\_ | Buena | \_\_ | Regular | \_\_ | Pobre |
| **Se han afectado sus actividades sociales en las ultimas 4 semanas :** | \_\_ | Nada | \_\_ | Un poco | \_\_ | Moderado | \_\_ | Bastante | \_\_ | Extremo |

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| **General:** | \_\_ | Fatiga | \_\_ | Debilidad | \_\_ | Fiebre / Chills | \_\_ | Cambio en peso | \_\_ | Sudando en la noche |
| **Piel:** | \_\_ | Dolor | \_\_ | Rash | \_\_ | Rubor | \_\_ | Picazon | \_\_ | Eczema |
| **Ojos:** | \_\_ | Dolor | \_\_ | Descarga | \_\_ | Infeccion | \_\_ | Problema de vision |  |  |
| **Oidos:** | \_\_ | Dolor | \_\_ | Descarga | \_\_ | Infeccion | \_\_ | Problema escuchando | \_\_ | Pitos en oidos |
| **Naris:** | \_\_ | Dolor | \_\_ | Sangrado | \_\_ | Infeccion | \_\_ | Problema de oler | \_\_ | Obstruccion |
| **Boca/Garganta:** | \_\_ | Dolor | \_\_ | Sangrado | \_\_ | Enfermedad de encias | \_\_ | Problema de sabor | \_\_ | Lesiones |
| **Corazon:** | \_\_ | Dolor | \_\_ | Palpitaciones | \_\_ | Hinchazon | \_\_ | Murmullos | \_\_ | Desmayo |
| **Pulmones:** | \_\_ | Dolor | \_\_ | Tos | \_\_ | Flema | \_\_ | Problema respiracion | \_\_ | Sangrado |
| **Gastrointestinal:** | \_\_ | Dolor | \_\_ | Nausea | \_\_ | Diarrhea | \_\_ | Constipado | \_\_ | Cambio de Peso |
| **Genitourinario:** | \_\_ | Dolor | \_\_ | Descarga | \_\_ | Sangre en la orina | \_\_ | Incontinencia | \_\_ | Urinacion Frecuente |
|  | \_\_ | Esterilidad | \_\_ | Impotencia | \_\_ | Sangrado Irregular | \_\_ | Amenorrhea |  |  |
| **Endocrino;** | \_\_ | Perdida de cabello | \_\_ | Sediento | \_\_ | Tremores | \_\_ | Intolerancia calor/frio | \_\_ | Problemas al dormir |
| **Neurologico:** | \_\_ | Dolor de Cabeza | \_\_ | Agarrotamiento | \_\_ | Vertigo | \_\_ | Adormecimiento |  |  |

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| **Aplicacion para Tratamiento Quiropractico** |  |  |  |  |
|  |  |  |  |  |  |  |
| Tipo de tratamiento deseado: |  | Alivio Temporero |  | Correccion Permanente |  |  |
|  |  |  |  |  |  |  |
| Esta interesado en mejorar su estado de salud? |  | Si |  | No |  |  |  |  |
|  |  |  |  |  |  |  |
| Entiendo y acepto que las pólizas de seguro de salud y accidentes son un acuerdo entre la compañía de seguros y el y yo. Entiendo que la oficina del doctor preparará los informes y formularios para que me ayude en la toma de la colección de la compañía de seguros y que cualquier cantidad autorizada a pagar directamente a la oficina del doctor se acreditarán en mi cuenta en el recibo necesarias. Entiendo claramente y estoy de acuerdo que todos los servicios prestados y me pagan a mí son mi responsabilidad que se pagará al médico. También entiendo que si suspender o terminar mi cuidado y tratamiento, los honorarios por servicios profesionales prestados conmigo será debido y pagadero inmediatamente. |
| **FIRMA DEL PACIENTE** |  | **FECHA** |  |
| **FIRMA DEL GUARDIAN** |  | **FECHA** |  |