Edward Cremata, DC, FNP-C
Cell: 510-913-1366 Fax: 925-237-8246
Mailing address: 15529 S. Winged Trace Ct.; Draper, Utah 84020

Patient Information

Name:_____
First Middle Initial Last

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____Cell #: _____

Email Address: _____

Gender: ☐ Male ☐ Female ☐N/A Date of Birth: _____ Social Security #_____

Driver's License State & #: _____ Occupation: _____

Employer: _____ Employer Address: _____

Employer City: _____ State: _____ Zip: _____

How did you hear about us? _____

Briefly describe what services you're seeking today. _____

_____

Emergency Contact

Name: _____Relationship to patient:_____

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

Date of Birth: _____Cell Phone #: _____ Email: _____

Employer:_____Work Phone #: _____

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

Payment Policy: Payment is expected at the time of service. **You are responsible for all charges incurred**. Your cooperation in this matter is appreciated.

Authorization: I certify that the above information is true and consent to the performance of examination and any medical or surgical treatment which may be necessary or advisable in the opinion of the physician. I also understand that payment is expected at the time of service and I request that my medical records be released as necessary for medical referral and/or insurance information. Your signature here will also serve as an assignment of benefits for insurance billing purposes.

Signature of Patient: _____

Signature of Parent/Guardian (if applicable: _____

Date Signed: _____

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Name:_____ DOB:_____

Gender: ☐ Male ☐ Female ☐Other _____

Health History

Have you ever had or do you have any of the following? (Please check Present, Past, or Leave Blank if Not Applicable.)

Past	Present	Condition	Past	Present	
		Severe or chronic headaches			Chronic rash
		Head Injury			Central Nervous System disorder
		Visual loss			Physiological disorder
		Eye problems (blurred or double vision, etc.)			Parasitic or infection diarrhea
		Glasses or contact lenses			Kidney or Urological issue
		Hearing loss			Broken bones or dislocations
		Ear problems (infections, ringing, etc.)			Bone or joint problems
		Hay fever			Hemorrhoids
		Sinus problems			Anemia
		Chronic cough			Tumor or Cancer
		Asthma			Recurrent fevers
		Problems breathing			Serious infections
		Heart trouble			Gland or hormone problems
		Chest pain			Tuberculosis
		High blood pressure			Diabetes
		Rheumatic fever			Thyroid problems
		Stomach problems			Fainting spells
		Ulcers			Convulsions or epilepsy
		Gallbladder problems			Complications from childhood diseases
		Ulcerative Colitis			Back pain or back injury
		Chron's disease			Neck pain or neck injury
		Diverticulitis			Tailbone pain or tailbone injury
		Jaundice (hepatitis)			Prostate problems
		Skin problems			Gynecological problems

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Social History

Past	Present	Habit	How much, How often, How long?
		Alcohol use	
		Cigarette use	
		Chewing tobacco use	
		Drug Use	

Do you have any allergies? ☐Yes ☐No. If yes, please list _____
_____

Are you allergic to any medication? ☐Yes ☐No. If yes, please list medication(s) and reaction. _____
_____
_____

Are you currently taking any medications? ☐Yes ☐No. If yes, please list medication(s), dosage, and frequency. _____
_____
_____
_____

Have you ever had a work-loss injury or illness? ☐Yes ☐No . If yes, please explain briefly. _____
_____

Have you ever received compensation for an industrial injury? ☐Yes ☐No. If yes, please explain briefly. _____
_____

Have you ever been injured in a motor vehicle accident? ☐Yes ☐No. If yes, please explain briefly. _____
_____

Are you presently under a doctor's care for any condition? ☐Yes ☐No. If yes, please explain briefly. _____
_____

Have you ever been hospitalized or had any operations? ☐Yes ☐No. If yes, please explain briefly (include dates). _____
_____

What health problems are present in your immediate family? (i.e. Mother, Father, Brothers, Sisters)_____
_____

What health problems are present in your extended family? (i.e. Grandparents, Aunts, Uncles) _____
_____

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	Date of Most Recent	Results
Chest X-Ray		
Spine X-Ray		
MRI		
Blood Work		
PAP Smear		

I certify that the above answers are complete and accurate to the best of my knowledge.

Signature of Patient_____Date_____

Signature of Parent or Guardian, if applicable: _____

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Printed Name: _____ Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

In the course of your care as a patient of Relief Medical Group, Inc., we may use or disclose personal and health related information about you in the following ways:

1. Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or maybe responsible for the payment of services provided to you.
3. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that maybe of interest to you.
4. You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.
5. Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, to your present care, or other health related information that may be of interest to you.
6. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

1. If we provide health care services to you in an emergency.
2. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
4. If we are ordered by the courts *or* another appropriate agency.
5. You have a right to receive an accounting of any such disclosures made by this office.

Any use of disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or it you would like the information in a specific form please advise us in writing as to your preferences. You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply to all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Edward Cremata. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which it was created. My signature acknowledges that I have read and received a copy of this notice.

Printed Name: _____

Signature of Patient or Authorized Representative: _____

Date Signed: _____

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1) The Health Information Portability and Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further been explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2) The Practice reserves the right to change its privacy practices that are described in the Privacy Notice, in accordance with applicable law.
3) I understand that, and consent to, the following: appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me: and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone. I also understand that, and consent to being sent birthday and holiday cards and newsletters, and my name appearing on various boards in the office.
4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct specific health care operations.
5) I understand that I have the right to request that the doctor restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the doctor is not required to agree to any restrictions that I have requested. If the doctor agrees to a requested restriction, then the restriction is binding on the doctor.
6) I understand that this Consent is valid for seven years. I further understand that I have the right to revoke the Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the doctor will not treat me.
9) I understand, and consent to, an open door / open wall environment for adjusting and therapy, and conversations with doctors, staff, or others may be overheard. I also consent to my name appearing on the sign-in sheets and appointment book which will be visible to others.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Printed Name: _____

Signature of Patient or Authorized Representative: _____

Date Signed: _____

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Insurance Coverage

Dr. Cremata is not in network with any insurance companies, and is currently only accepting patients that pay per services rendered. I fully understand that I am responsible for any service charges incurred, and will pay at the time of service.

Printed Name: _____

Signature of Patient or Authorized Representative: _____

Date Signed: _____

Informed Consent

I hereby request and consent to the performance of medical services and other procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, to me by the FNP-C named above and/or anyone working in this clinic authorized by the FNP-C listed above. I am aware that I have an opportunity to discuss the FNP-C named above and/or with other office personnel, including Edward Cremata, DC, FNP-C, the nature and purpose of medical services and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of medicine there are some risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, fractures, dislocations, and strokes. I do not expect the doctor to anticipate and explain all risks, and I wish to rely on the doctor to exercise good judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and in my best interests. Any medication provided, by oral, injection, or any other route has risks involved and it is recommended that the patient is educated and asks the doctor or nurse questions about the medication for full informed consent prior to taking them.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name: _____

Signature of Patient or Authorized Representative: _____

Date Signed: _____