lazar
UPPER CERCICAL

DMX Patient Form

Digital Motion X-ray · Ann Arbor, Michigan

Lazar Upper Cervical · 203 S. Zeeb Rd, Suite 106, Ann Arbor, MI 48103 · 734.274.5107 · hello@lazaruppercervical.com

PATIENT INFORMATION

Today's date MM/DD/YYYY

First name

Last name

Date of birth MM/DD/YYYY

Mobile phone

Other phone

Email

Street address

City

State

ZIP

Text me appointment reminders

☐ Yes ☐ No

Yes means: I agree to receive text messages from Lazar Upper Cervical about my appointments. Message frequency varies. Message and data rates may apply. Reply STOP to opt out, HELP for help. Optional, and not a condition of receiving care.

Emergency contact

Relationship

Their phone

Primary care doctor

Office phone

Referring doctor, if any

Office phone or fax

AUTO ACCIDENT AND MEDICAL PAYMENTS (MEDPAY)

Fill this in only if the study is related to an auto accident and your auto policy has medical payments (MedPay) coverage.

Is this study related to an auto accident?

☐ Yes ☐ No

Date of the accident MM/DD/YYYY

Auto insurance company

Company address

City

State

ZIP

Company phone

Company fax

Policy or claim number

Adjuster's name

Adjuster's phone

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NECK AND BACK QUESTIONNAIRE

In your own words, what would you like the motion study to look at?

How long? Years _____ Months _____ Weeks _____

Is this the first time? ☐ Yes ☐ No

Did this start with an injury, such as a car accident, fall, sports injury or concussion?
☐ Yes ☐ No

If yes, what happened and when?

X-rays, MRI or CT of your neck before?
☐ Yes ☐ No

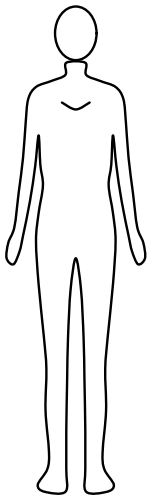
If yes, which and when?

Right now, how strong are your symptoms? 0 is none, 10 is the worst you can imagine.
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

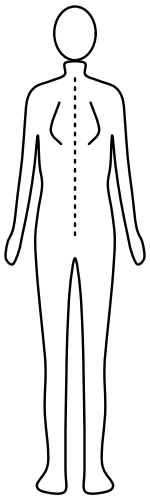
Occupation

Mark where you feel symptoms right now. Use the letters in the key: write them on the figure, or next to each area.

Key **A** = Ache **B** = Burning **N** = Numbness **P** = Pins and needles **S** = Stabbing **O** = Other



Front



Back


Right side

Area	Letters	Area	Letters
Head		Left arm or elbow	
Jaw		Right hand or wrist	
Neck		Left hand or wrist	
Upper back		Right hip	
Mid back		Left hip	
Low back		Right leg or knee	
Right shoulder		Left leg or knee	
Left shoulder		Right foot or ankle	
Right arm or elbow		Left foot or ankle	

Notes on the chart, such as what Other means for you

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CONSENT FOR DIGITAL MOTION X-RAY (DMX)

- I ask for and agree to a digital motion X-ray (DMX) study. The study is performed at Lazar Upper Cervical by Dr. Jonathan Lazar, D.C., or someone personally trained by him.
- I understand that DMX is an X-ray video: it records the bones of my neck while I move. Like any X-ray, it involves a dose of radiation, and the study is kept as short as it can be.
- I will tell the team before the study if I am or may be pregnant.
- DMX is a diagnostic study. It shows how the bones move. It is not care by itself, and no result is promised.
- My images and findings become part of my record at Lazar Upper Cervical. With my permission, they are sent to the doctor who referred me.
- I may ask questions at any time, and I may withdraw this consent before the study begins. For a patient under 18, a parent or legal guardian signs.

Is there any chance you are pregnant?

☐ No ☐ Yes ☐ Not sure ☐ Does not apply

☐ I have read this consent, my questions have been answered, and I agree to the DMX study.

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices explains how your health information is used and shared, and your rights. Read it at app.lazaruppercervical.com/policies, or ask for a printed copy at the front desk.

☐ I acknowledge that I have been offered Lazar Upper Cervical's Notice of Privacy Practices.

SIGNATURE

I am signing as

☐ The patient ☐ Parent or legal guardian

Signature of the patient, or parent or legal guardian (sign, or type your full name) _____

Date MM/DD/YYYY _____

Relationship to the patient, if not the patient _____

Office use: received by _____ on _____