PATIENT INFORMATION

Name _____ Today's Date _____

Date of Birth _____ Height _____ Weight _____ Dominant Hand? R L

Address _____ City _____ Zip _____

Phone (cell) _____ Phone (other) _____

email _____ DL# _____

Health Insurance Company _____ Policy# _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Car Insurance Company _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Agent _____ Phone _____

Policy # _____ Claim # _____

What Medical Payments Coverage? _____ What Uninsured Motorist Coverage? _____

What Law Firm Represents You? _____

Address _____ City _____ Zip _____

Your Lawyer's Name? _____ Phone _____

Name of Insured on your Car Policy _____ For office use only Patient # _____

Date of Loss/Accident? _____ Date you first saw *any* Doctor after accident _____

Cost of all medical treatment since the accident? $ _____

How much income have you lost since the accident $ _____

What is the property damage (repair amount) of your car? $ _____

Name of your Personal M.D. _____ Phone _____

Address _____ City _____ Zip _____

Write any Ambulance, Hospital, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc., since accident

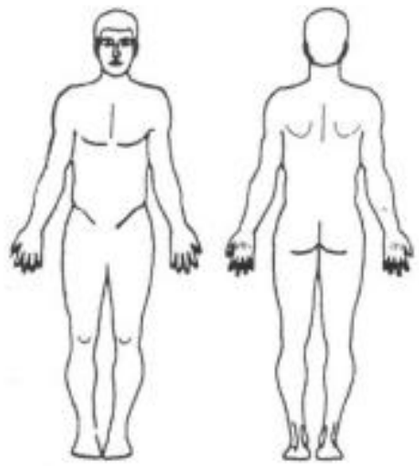
Name	Type	Phone#	Amount of Bill	For office use only Records Rec'd

Please use other side of page to write additional doctors & hospitals

INITIAL HEALTH STATUS
(Chiropractic)

Patient Name: _____ Birthdate: _____ Sex: M / F Telephone: _____
Address: _____ City: _____ State: _____ Zip: _____
Drivers License: _____ Occupation: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

_____

_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/ Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications: _____
☐	☐	Cancer/Tumor			_____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma (Falls, Car Accidents)			_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

Authorizations and Release Form

Name_____Case#_____

Consent for Treatment

I, the undersigned, hereby authorize ***Personal Touch Chiropractic*** and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs and to administer treatment as necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND DISAGREE THAT ALL SERVICE RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT IAM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's Signature_____Date_____/_____/___Witness_____

Authorization to Release a Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____Date_____/_____/_____Witness_____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____Insurance Company/Insurance Administrator to pay by check directly to: **Personal Touch Chiropractic** 6820 La Tijera Blvd, Suite 208A Los Angeles, CA 90045. The expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional service rendered, I have agreed to pay in a current manner. Any balance of said applicable charges, I agree that this office be given power of attorney endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____Date_____/_____/_____Witness_____

Attorney Representation and Protection of Balance

I, the undersigned patient am directing my Attorney, _____ to pay any outstanding bills out of my settle and in effect, any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said funds. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's Signature_____Date_____/_____/_____Witness_____

X Ray/Medical Records Release

I have requested the release of records of (patient's name) _____ as part of the records at (facility) _____.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing, copies of my records and reports, including copies of x-rays. Abstract or excerpts of all records and any other information they request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have or may have in the future. Please email information to: PersonalTouch22@yahoo.com

Patient's Signature_____Date_____/___/_____Witness_____

Consent for Treatment of Minor

I hereby authorize _____. D.C and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs and to administer as he/she deems necessary to my (indicate relationship of child)_____ (child's name) _____

Guardian's Signature_____Date_____/_____/_____Witness_____