Dr. Williams *Chiropractic Office*

(909) 592-2823

PATIENT INFORMATION

Legal First Name: _____ **MI:** _____ **Last Name:** _____

Street Address: _____ **Apartment:** _____

City: _____ **State:** _____ **Zip:** _____

Social Security: _____-_____-_____ **Marital Status: Single Married Divorced Spouse:** _____

Language: English _____ **Spanish** _____ **Indian** _____ **Japanese** ____ **Chinese** ____ **Korean** _____ **French** ____

German _____ **Russian** _____ **Other** _____

Race: African American _____ **Alaska Native** _____ **American Indian** _____ **Asian** _____ **Black** _____

Hispanic _____ **Latino** _____ **Native Hawaiian** _____ **Pacific Islander** _____ **Spanish** _____

White _____ **Decline To Answer** _____

Date Of Birth: _____ **Home Phone Number:** (_____) - _____-_____

Work Number: (_____) - _____-_____

Cell Phone Number: (_____) - _____-_____ **Cell Carrier:** _____

Contact Preference: Home Number: _____ **Work Number:** _____ **Cell Number:** _____ **E-Mail** _____

U.S.Postage: _____

E-Mail Home: _____ **E-Mail Work:** _____

Emergency Contact Person: _____ **Phone Number:** (_____) - _____-_-_____

Whom May We Thank For Referring You To Our Office? _____

Occupation: _____ **Employer:** _____

Employer's Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** (_____) - _____-_____

DATE: _____/_____/_____ ***PATIENT/INSURED/GUARDIAN SIGNATURE:*** _____

Waites Earl Williams, Jr., D.C., QME
Dr. Williams *Chiropractic Office*
Post Office Box 3176
San Dimas, California 91773
(909) 592-2823

DATE: ____/____/_____ **CLAIM NUMBER – POLICY NUMBER: _____**

ASSIGNMENT OF INSURANCE BENEFITS – POWER OF ATTORNEY

I (Patient – Guardian - Insured), _____, voluntarily and intentionally assign medical payments to *Waites Earl Williams, Jr., D.C., aka Dr. Williams Chiropractic Office.*
I further instruct that any and all payments due under my motor vehicle medical payments – health care insurance policy be made payable and directly to the doctor and/or doctor's office mentioned above. If my motor vehicle medical payments - health care insurance policy has a prohibition of assignment clause and does not allow assignment of benefits under the policy, then I instruct and direct my motor vehicle medical payments - health care insurance company to make payments (checks/insurance draft) payable to me (Patient/Insured) but to mail the payments (checks/insurance draft) to the doctor and/or doctor's office address mentioned above.

In *Flour Corp v. Superior Court Case,* the Supreme Court reversed Henkel & stated in part; *it bars an insurer "after a loss has happened," from refusing to honor an insured's assignment of the right to invoke the insurance policy's coverage for such a loss.*

Failure to comply with this signed assignment whether it is an original or a copy will be a violation of Insurance Code Section 790.03 and will be considered a violation of my rights under my health care insurance policy.

I (Patient – Guardian - Insured), _____, agree to pay any applicable deductible, co-payments as well as the balance due after the medical insurance payments is exhausted and/or thirty (30) days after release from chiropractic care for this accident/injury as well as for any other services rendered by *Waites Earl Williams, Jr., D.C., aka Dr. Williams Chiropractic Office.*

POWER OF ATTORNEY

Waites Earl Williams, Jr., D.C., aka Dr. Williams Chiropractic Office* is hereby given the power of attorney by patient – guardian - insured to sign my name on any checks issued for payment for services rendered by *Waites Earl Williams, Jr., D.C., aka Dr. Williams Chiropractic Office.
I certify that I (Patient – Guardian - Insured), _____, have not been solicited or promised anything in exchange for receiving chiropractic services or that I (Patient – Guardian - Insured) have received any promises or guarantees from Waites Earl Williams, Jr., D.C., *aka* Dr. Williams *Chiropractic Office* as to the results that may be obtained by services rendered by Waites Earl Williams, Jr., D.C., *aka* Dr. Williams *Chiropractic Office.*

I further allow Waites Earl Williams, Jr., D.C., *aka* Dr. Williams *Chiropractic Office* to allow a photocopy of my signature to be used to deposit - cash my motor vehicle payments - health care insurance company claims payments and this right can only be revoked by me in writing to the doctor/doctor's office and to my motor vehicle payments insurance company - health care insurance company.

Dr. Williams *Chiropractic Office*

RELEASE OF MEDICAL RECORDS AND BILLING

I (Patient/Insured/Guardian) _____
authorize;

Waites Earl Williams, Jr., D.C., QME
Dr. Williams *Chiropractic Office*
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To release any information necessary to my health care insurance company regarding my condition(s)/illness and my treatment(s).

To process health care insurance claims generated in the course of my examination(s), x-rays, special test(s) as well as any treatment(s).

To allow a photocopy of my signature to be used to process my health care insurance claims and this right can only be revoked by me in writing to the doctor/doctor's office and my health care insurance company.

A photocopy of this release of medical records and billing shall be as valid as a signed original.

DATE: ____/____/_____ CLAIM NUMBER – POLICY NUMBER: _____

_____ _____

Patient's Name - Please Print ***Patient's Name - Signature***

A Dated & Signed Copy Of This Motor Vehicle Medical Payments – Health Care Insurance Policy Benefits - Power Of Attorney & Release Of Medical Records & Billing Shall Be As Valid As The Dated And Signed Original.

DATE: ____/____/_____ CLAIM NUMBER – POLICY NUMBER: _____

_____ _____

Patient's Name - Please Print ***Patient's Name - Signature***

If Applicable

_____ _____

Guardian - Parent Name - Please Print ***Guarding - Parent Name – Signature***

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DISCLOSURE & CONSENT
CHIROPRACTIC TREATMENT AND CHIROPRACTIC ADJUSTMENT(S)

TO THE PATIENT

You have a right as a patient to be informed about your condition, the recommended chiropractic treatment and the potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to treatment.

I (patient-guardian) request and consent to the performance of chiropractic procedures including but not limited to; orthopedic/neurological examination(s), diagnostic x-rays, various modes of physical therapy (heat packs, ice packs, therapeutic massage, transcutaneous nerve stimulation & ultra-sound) as well as chiropractic adjustments. The chiropractic treatment may be performed by the *Waites Earl Williams, Jr., D.C., QME.* Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for *Waites Earl Williams, Jr., D.C., QME.* I also acknowledge that I (patient-guardian) am financially responsible for all chiropractic services provided by *Waites Earl Williams, Jr., D.C., QME* and/or Dr. Williams *Chiropractic Office.*

I have had the opportunity to discuss with *Waites Earl Williams, Jr., D.C., QME,* my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment and the risks and benefits of alternative treatment including no treatment at all. I understand and I am informed that there are some risks to the performance of chiropractic procedures including but not limited to; orthopedic/neurological examination(s), diagnostic x-rays, various modes of physical therapy (heat packs, ice packs, therapeutic massage, transcutaneous nerve stimulation & ultra-sound) as well as chiropractic adjustments but not limited to:

PLEASE INITIAL ON EACH LINE BELOW

_____ **Fractures (broken bones)**	_____ **Increased Symptoms & Pain**
_____ **Spinal or Disc Injuries**	_____ **No Improvement of Symptoms/Pain**
_____ **Dislocations**	_____ **Stroke**
_____ **Sprains/Strains**	_____ **Condition(s) Not Revealed By Patient**

I do not expect *Waites Earl Williams, Jr., D.C., QME,* to be able to anticipate and explain all risks and complications. I wish to rely on *Waites Earl Williams, Jr., D.C., QME,* to exercise judgment during the course of my chiropractic treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the chiropractic treatment.

TO BE COMPLETED BY THE PATIENT

Date: ____/____/_____ _____ _____

Print Name | ***Signature Of Patient***

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE

Date: ____/____/_____ _____ _____

Print Patient's Name | **Print Name Of Patient's Representative**

_____ _____

Signature Of Patient's Representative | **Relationship/Authority To Patient**

TO BE COMPLETED BY Dr. Williams *Chiropractic Office*

Date: ____/____/_____ _____ _____

Print - Witness To Patient's Signature | ***Signature – Witness To Patient's Signature***

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MOTOR VEHICLE CASE HISTORY

PLEASE PRINT

First Name: _____ **M.I.:** _____ **Last Name:** _____

Date Of Accident: _____ **Time Of Accident:** _____ **A.M.** _____ **P.M.** _____

You Were Heading: North _____ **South** _____ **West** _____ **East** _____ **Traveling At** _____ **M.P.H.**

The Other Motor Vehicle Was Heading: North _____ **South** _____ **West** _____ **East** _____ **At** _____ **M.P.H.**

On (Freeway, Highway Or Street) _____

In The City Of: _____ **In The State Of:** _____

You Were The: Driver _____ **Passenger** _____ **(If You Were The Passenger You Were Sitting In The):**

Front Right Seat _____ **Left Rear Seat (Behind Driver)** _____ **Right Rear Seat (Behind Passenger)** _____

Your Motor Vehicle Was Struck On The: Rear _____ **Front** _____ **Right Side** _____ **Left Side** _____

Did You Receive Medical Attention At The Accident Scene? _____ **Were You Conscious:** _____

Did You Go To A Medical Facility/Physician For Treatment After The Accident? _____ **If Yes, Where**

_____

Where Do You Feel Pain? _____

_____

_____

Is Your Pain: Improving _____ **Same** _____ **Getting Worse** _____ **Other** _____

_____

Do You Have An Attorney? _____ **If Yes – Please Be Advised/Aware Dr. Williams *Chiropractic Office* Does Not Treat Any Motor Vehicle Accident Patient(s) Represented By An Attorney**

HOWEVER

Dr. Williams *Chiropractic Office* Will Treat Motor Vehicle Accident Patient(s) With Medical Payment Motor Vehicle Insurance In Which Dr. Williams *Chiropractic Office* Will Receive Direct Payment From The Patient(s) Medical Payment Insurance Company Or Direct Payment From The Patient(s)!

PATIENT'S – GUARDIAN'S ADDITIONAL NOTE(S)

_____

_____

_____

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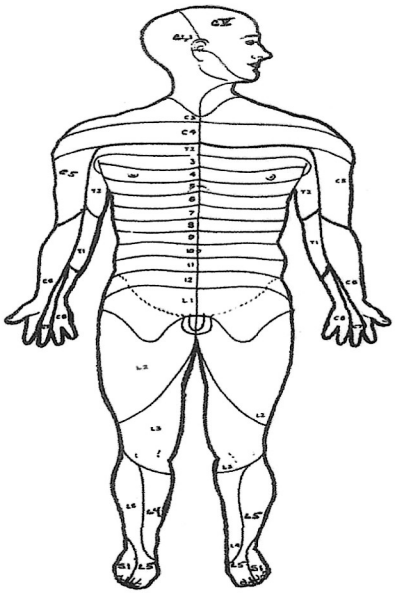
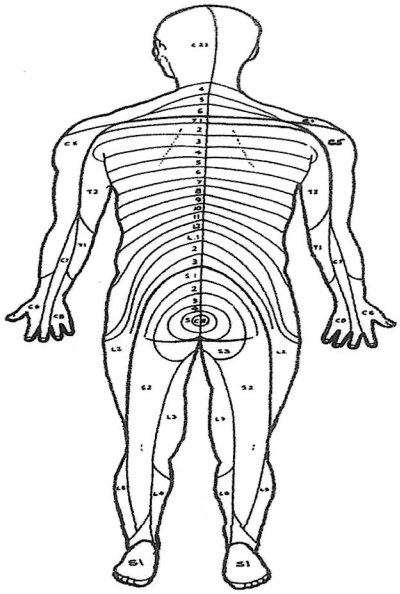
Please Mark Area(s) & Type of Pain On The Drawings Using The Codes Listed Below

A-Ache N-Numbness P-Pain S-Soreness ST–Stiffness T-Tingling





In order for this office to properly serve you and help your condition, we need to know which of the following chiropractic treatment plans you desire.

Acute Care aka Aspirin Care _____
I just want the pain to go away.

Rehabilitative Care aka Current Condition Care _____
I want the pain to go away and to correct the problem.

Preventative Care aka Wellness Care _____
I want to have regular chiropractic and spinal care.

Dr. Williams *Chiropractic Office* Financial Policy

I, the patient – guardian, understand Dr. Williams *Chiropractic Office* does not have a contract with my insurance company for chiropractic service(s) rendered therefore I, the patient - guardian, am financially responsible for all x-ray's, braces, orthopedic supports, supplements, vitamins as well as chiropractic service(s) rendered and payment is due when chiropractic service(s) are rendered!

Date ____/____/____ ***Patient's – Guardian's Signature*** _____

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PLEASE CHECK ALL PRESENT SYMPTOMS

DATE ____/____/_____ **NAME** _____

PRINT FIRST PRINT MIDDLE PRINT LAST

PLEASE CIRCLE RIGHT OR LEFT

HEAD

- ____ HEADACHES
- ____ SINUS
- ____ MIGRAINE HEADACHE
- ____ HEADACHE ON TOP OF HEAD
- ____ HEADACHE ON BACK OF HEAD
- ____ HEADACHE ON FOREHEAD
- ____ HEADACHE ON SIDE OF HEAD
- ____ HEAD FEELS HEAVY
- ____ LIGHT HEADEDNESS
- ____ DIZZINESS
- ____ RINGING IN EARS

NECK

- ____ PAIN IN NECK
- ____ NECK PAIN WITH MOVEMENT
- ____ MUSCLE SPASMS

SHOULDERS

- ____ PAIN IN RIGHT SHOULDER
- ____ PAIN IN LEFT SHOULDER
- ____ PAIN ACROSS SHOULDERS
- ____ UNABLE TO MOVE SHOULDER
- ____ MUSCLE SPASMS IN SHOULDER

ARMS & HANDS

- ____ PAIN IN UPPER RIGHT OR LEFT ARM
- ____ PAIN IN RIGHT OR LEFT ELBOW
- ____ PAIN IN RIGHT OR LEFT FOREARM
- ____ PAIN IN RIGHT OR LEFT HAND
- ____ NUMBNESS IN RIGHT OR LEFT EXTREMITY

MID - BACK

- ____ MID BACK PAIN
- ____ DULL PAIN
- ____ SHARP PAIN

ABDOMEN

- ____ STOMACH PAIN
- ____ GAS
- ____ CONSTIPATION
- ____ DIARRHEA
- ____ NAUSEA
- ____ HEMORRHOIDS

LOWER BACK

- ____ LOW BACK PAIN
- ____ LOW BACK PAIN UPON MOVEMENT
- ____ MUSCLE SPASMS

CHEST

- ____ CHEST PAIN
- ____ RADIATING CHEST PAIN
- ____ SHORTNESS OF BREATH
- ____ BREAST PAIN RIGHT OR LEFT

LEGS & FEET

- ____ PAIN IN UPPER RIGHT OR LEFT LEG
- ____ PAIN IN RIGHT OR LEFT KNEE
- ____ PAIN IN RIGHT OR LEFT LEG
- ____ PAIN IN RIGHT OR LEFT ANKLE
- ____ PAIN IN RIGHT OR LEFT FOOT

NOTES

_____

_____

_____