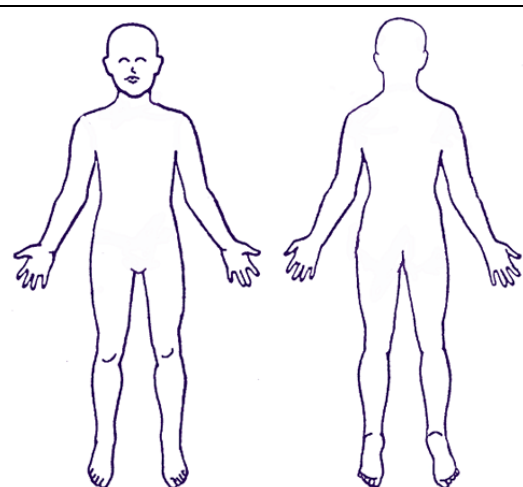


**PATIENT CONFIDENTIAL FORM**

**HOW DID YOU HEAR ABOUT US?**  WEBSITE  FRIENDS  WALK IN  OTHER: \_\_\_\_\_  
**PATIENT NAME:** \_\_\_\_\_ **SEX:** M F **AGE:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_/\_\_\_/\_\_\_  
**PATIENT ADDRESS (NO PO BOXES, PLEASE):** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**HOME PHONE:** (\_\_\_\_) \_\_\_\_\_ **WORK:** (\_\_\_\_) \_\_\_\_\_ **MOBILE:** (\_\_\_\_) \_\_\_\_\_ **E-MAIL:** \_\_\_\_\_@\_\_\_\_\_  
**OCCUPATION:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_ (FULL TIME) (PART TIME) (RETIRED)  
**EMPLOYER ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ **TEL:** (\_\_\_\_) \_\_\_\_\_ **PREVIOUS CHIROPRACTOR:** \_\_\_\_\_ **TEL:** (\_\_\_\_) \_\_\_\_\_

**MARITAL STATUS:**  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED **SPOUSE NAME:** \_\_\_\_\_  
**NUMBER OF CHILDREN:** \_\_\_\_\_ **EMERGENCY CONTACT NAME:** \_\_\_\_\_ **EMERGENCY TEL. NUMBER:** (\_\_\_\_) \_\_\_\_\_

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**  
 HEADACHE  NECK PAIN  MID-BACK PAIN  LOW BACK PAIN  
 OTHER: \_\_\_\_\_  
**IS THIS COMPLAINT RELATED TO?**  AUTO  WORK  OTHER: \_\_\_\_\_  
**IS THIS COMPLAINT?**  NEW  FLARE UP  CHRONIC  \_\_\_\_\_  
**DATE PROBLEM BEGAN?** \_\_\_\_\_  
**HOW PROBLEM BEGAN?** \_\_\_\_\_  
**HOW OFTEN DO YOUR SYMPTOMS PRESENT?**  
 0-25% INTERMITTENT  26-50%  51-75%  76-100% CONSTANT  
**HOW MUCH YOUR DISCOMFORT INTERFERES WITH YOUR DAILY ACTIVITIES?**  
 WORK  SOCIAL ACTIVITIES  EXERCISES  RELATIONSHIP  HOUSEHOLD CHORES  
 NO INTERFERENCE 1 2 3 4 5 6 7 8 9 10 UNABLE TO CARRY ON ANY ACTIVITIES  
**HAVE YOU HAD PRIOR EPISODES? WHEN?** \_\_\_\_\_  
**WHAT MAKES YOUR SYMPTOMS BETTER?** \_\_\_\_\_  
**WHAT MAKES YOUR SYMPTOMS WORSE?** \_\_\_\_\_

**MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.**  
  
**ON A SCALE OF 1-10 RATE YOUR DISCOMFORT:**  
 NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

**HAVE YOU SEEN ANY HEALTH PROFESSIONAL FOR YOUR SYMPTOMS?**  
 NO ONE  OTHER CHIROPRACTOR  MEDICAL DOCTOR  PHYSICAL THERAPIST  OTHER \_\_\_\_\_  
**WHAT TREATMENT DID YOU RECEIVE AND WHEN?** \_\_\_\_\_

**HAVE YOU HAD X-RAYS, MRI OR ANY OTHER TYPE OF IMAGING OR TEST FOR YOUR AREA OF COMPLAINT?** YES NO  
**WHAT AREA:** \_\_\_\_\_ **WHAT TEST:** \_\_\_\_\_ **DATE:** \_\_\_/\_\_\_/\_\_\_

**PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU:**

<input type="checkbox"/> NUMBNESS IN GROIN/ BUTTOCKS <input type="checkbox"/> CANCER/ TUMORS/ LUMPS (EXPLAIN) _____ <input type="checkbox"/> STROKE/ CARDIAC ARREST(DATE) ___/___/___ <input type="checkbox"/> DIABETES/ INSULIN USE <input type="checkbox"/> RECENT FEVER/ INFECTION OF MUSCLE/ JOINT <input type="checkbox"/> HEART PROBLEMS/ HIGH BLOOD PRESSURE <input type="checkbox"/> DIZZINESS/ LACK OF BALANCE/ TREMOR <input type="checkbox"/> CHEST PAIN/ SHORTNESS OF BREATH/ COUGH <input type="checkbox"/> PAIN AT NIGHT/ NIGHT SWEATS <input type="checkbox"/> OSTEOPOROSIS/ MUSCLE WEAKNESS/ CRAMPS <input type="checkbox"/> HORMONE THERAPY	<input type="checkbox"/> URINARY, PROSTATE PROBLEMS/ FREQUENCY OR RETENTION <input type="checkbox"/> MENSTRUAL, REGULARITY PROBLEMS/ VAGINAL DISCHARGE <input type="checkbox"/> STOMACH, INTESTINAL PROBLEMS/ BLOOD IN STOOL <input type="checkbox"/> ABNORMAL WEIGHT CHANGES/ FATIGUE <input type="checkbox"/> SKIN COLOR/TEXTURE CHANGES, BREAST DISCHARGE <input type="checkbox"/> EYES/ EARS/ NOSE/ MOUTH/ THROAT PROBLEMS <input type="checkbox"/> IF PREGNANT, # WEEKS ___ / TAKING BIRTH CONTROL <input type="checkbox"/> CORTICOSTEROID USE (PREDNISONE, ETC.) <input type="checkbox"/> EPILEPSY/ SEIZURES, NEUROLOGIC/PSYCHIATRIC PROBLEMS <input type="checkbox"/> ANEMIA, BLEEDING TENDENCY <input type="checkbox"/> ALLERGIES TO FOOD OR DRUGS, ETC. _____	<input type="checkbox"/> SURGERIES _____ <input type="checkbox"/> MEDICATIONS _____ <input type="checkbox"/> ACCIDENTS _____ <input type="checkbox"/> HOSPITALIZATIONS _____
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**FAMILY HISTORY OF:**  
 CANCER  DIABETES  HEART PROBLEMS/ STROKE  HIGH BLOOD PRESSURE  RHEUMATOID ARTHRITIS

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_/\_\_\_/\_\_\_  
**GUARDIAN'S SIGNATURE (FOR MINORS)** \_\_\_\_\_ **DATE:** \_\_\_/\_\_\_/\_\_\_

**I AM ALSO INTERESTED IN:**  
 WEIGHT MANAGEMENT  MASSAGE  FOOT/ARCH EXAM & ORTHOTICS  DETOXIFICATION

**Patient Information Form**

**PATIENT NAME:** \_\_\_\_\_ **SEX:** **M** **F** **AGE:** \_\_\_\_\_

HOW WOULD YOU LIKE US TO CONTACT YOU?  MOBILE #  HOME #  WORK #  E-MAIL  Other

**PRIMARY INSURANCE INFORMATION:**

INSURANCE CARRIER \_\_\_\_\_ ID# \_\_\_\_\_

EMPLOYMENT  AUTO ACCIDENT  OTHER ACCIDENT

GROUP # \_\_\_\_\_ INS. PHONE# (\_\_\_\_\_) \_\_\_\_\_

Text  Call

**GUARANTORS INFORMATION: (IF DIFFERENT FROM PATIENT)**

(FIRST) \_\_\_\_\_ (LAST) \_\_\_\_\_ (DOB) \_\_\_\_/\_\_\_\_/\_\_\_\_

GUARANTORS ADDRESS \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

GUARANTORS BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION / IS THIS A MEDICARE SUPPLEMENT** YES \_\_\_\_\_ NO \_\_\_\_\_

INSURANCE CARRIER \_\_\_\_\_ ID# \_\_\_\_\_

GROUP # \_\_\_\_\_ INS. PHONE # (\_\_\_\_\_) \_\_\_\_\_

**WORK RELATED OR PERSONAL INJURY INSURANCE?**  EMPLOYMENT  AUTO ACCIDENT  OTHER ACCIDENT

DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_ STATE WHERE THE INJURY OCCURRED: \_\_\_\_\_

INSURANCE CARRIER \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

CLAIMS ADDRESS (INCLUDE P.O. BOX) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CLAIM # \_\_\_\_\_ CLAIM ADJUSTER \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

**IF APPLICABLE:**

NAME OF ATTORNEY \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**I HEREBY CERTIFY THAT ALL THE INFORMATION IN THIS FORM IS TRUE AND CORRECT**

**PRINT NAME AND AUTHORITY (IF LEGAL REPRESENTATIVE)** \_\_\_\_\_

**Signature of Patient or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**OFFICE USE ONLY**

INSURANCE REPRESENTATIVE: \_\_\_\_\_ DATE VERIFIED COVERAGE: \_\_\_\_/\_\_\_\_/\_\_\_\_

REP. DIRECT PHONE #: \_\_\_\_\_ TIME VERIFIED: \_\_\_\_:\_\_\_\_ A.M. P.M.

INSURANCE COMPANY: \_\_\_\_\_ PRE-AUTHORIZATION #: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN TYPE: HMO\_\_ PPO\_\_ POS\_\_ OTHER:

**WHERE DO WE SEND CLAIMS?**

**CHIROPRACTIC ELIGIBILITY & BENEFITS:**

Allowed number of visits: \_\_\_\_\_ Visits used: \_\_\_\_\_ Coverage %: \_\_\_\_\_ Deductible \$ \_\_\_\_\_ / Calendar year Deductible \$ \_\_\_\_\_ met

**Foot Orthotics Coverage %:** \_\_\_\_\_ Yes No Codes covered: L3020 or L3030 Management/Training: 97760

Any conditions required such as Diabetes...: Yes No Need letter of medical necessity or pre-authorization? Yes No

Lumbar/Cervical Pillow E0190 covered? Yes No Appliances covered? Yes No

Tens and Supplies Covered? Yes No Supports and Braces Covered? Yes No

Massage Covered \$ \_\_\_\_? Yes No Supplements Covered? Yes No



CHIROPRACTIC, SPORTS REHAB, THERAPEUTIC MASSAGE  
 23332 Hawthorne Blvd., Suite 205, Torrance, CA, 90505  
 Tel: 310-294-9392, Fax: 310-373-4371

PATIENT AUTHORIZATION AND RESPONSIBILITY FORM

CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Advanced Body Care. I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts than known, and is in my best interest. I have read, or have had read to me, the above consent. By signing below, I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

AUTHORIZATION/ASSIGNMENT OF BENEFITS

We offer several methods of payment for your chiropractic care at our office and you may choose the plan which best fit your needs. Our main concern is your health and well being and we will do our best to help you.

- INSURANCE:** Advanced Body Care, will courtesy bill your insurance for you (not required by law). Please be advised that Insurance companies inform us at time of verification that any/all payments may vary upon submittance of claims. **You are required to pay any co-pays and yearly deductibles at time of service.**
- CASH:** Fees are to be paid at the time services are rendered, unless special arrangements have been made.
- AUTO INJURY:** You are required to supply us with the accident report, your car insurance, health insurance, liable parties insurance, and attorney if applicable. Until necessary information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event check should come to you, you are required to bring the check to us.

*I herby authorize and assign payment of any benefits due to me under the terms of any insurance policy or policies that may cover the procedure performed on me or my dependents by Advanced Body Care directly to Advanced Body Care at the address designated by on any claim form submitted to the insurance carrier.*

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices. I acknowledge that I have reviewed the Notice of Privacy Practices prior to signing this consent. I understand that Advanced Body Care reserves the right to change its Notice of Privacy Practices without notice to me.

FOR MEDICARE PATIENTS ONLY – AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I herby authorize the payment of authorized Medicare benefits be made on my behalf to Advanced Body Care for any services rendered. I also herby authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its agents, intermediaries or carriers any information needed to determine these benefits payable for related services. I further understand and agree that deductibles, coinsurances and any other charges not covered by Medicare are my responsibility.

PATIENT NAME: \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

GUARDIAN'S SIGNATURE (FOR MINORS) \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_