

Patient Notes

Patient Name: _____ Date: _____

Date of Injury: _____

History:

[illegible]

Findings:

[illegible]

Visits

Patient Name _____ is allowed _____ visits a year.

Insurance _____ Deductible _____ Payable _____ CoPay _____

	Date	Initials
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PATIENT INFORMATION

Name: _____ Date of Birth: _____
Age: _____ Social Security #: _____ Driver's Lic. # _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: () _____ Work Phone: () _____
e-mail _____ Number of Children _____
Sex: _____ Marital Status: _____ Spouse's Name _____
Occupation: _____ Employer: _____ Address _____

FINANCIAL INFORMATION

Who is responsible for this account? (Who is the primary insured?)

Relationship: _____
Insurance Company: _____
ID Number: _____ Group Number: _____
Policy Number: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named Insurance Company and hereby assign directly to Brian Ross, D.C. all insurance benefits, including all Insurance checks sent to the patient for services provided must be signed and brought into the doctor/ or mail directly to the office.

if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of my (this) signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____

What is the reason for your visit? Describe all of your health concerns _____

When did your symptoms first appear? _____

Since then, this condition has been : (Improving, Worsening, Unchanged): _____

ACCIDENT INFORMATION OR WORK INJURY IF NOT APPLICABLE WRITE NA

Is your condition due to an accident? _____ Date of accident: _____

Type of accident: (Auto, Work, Home, Other): _____

To whom have you made a report of your accident? (Auto Insurance, Employer, Worker Comp.) Other: _____

If this was an accident; please explain what happened:

Rate the severity of your pain from 1 (least pain) to 10 (severe pain): _____

Type of pain: __ Sharp __ Dull __ Burning __ Aching __ Shooting __ Stabbing __ Stiffness
__ Cramps __ Tingling __ Throbbing __ Numbness __ Swelling __ Other: _____

How often do you have this pain? _____ Is the Pain constant or come and go _____

Does the pain interfere with: __ Work __ Sleep __ Daily Routine __ Recreation

Activities or movements that are painful to perform: __ Sitting __ Standing __ Walking
__ Bending __ Lying Down __ Sleeping

HEALTH HISTORY

Name, address and specialty of other doctors who have treated you for this condition:

Check any of the following conditions that you have now or have had in the past:

__ AIDS/HIV __ Stroke __ Glaucoma __ High Cholesterol __ Bleeding Disorders
__ Allergies __ Cancer __ Heart Disease __ Kidney Disease __ Pacemaker
__ Anemia __ Diabetes __ Hepatitis __ Liver Disease __ Parkinson's Disease
__ Arthritis __ Hernia __ Headaches __ Prosthesis __ Breathing Problems
__ Asthma __ Epilepsy __ Herniated Disc __ Multiple Sclerosis __ Osteoporosis
__ Fractures __ Thyroid Problems __ Tuberculosis __ Tumors/Growths
__ High Blood Pressure __ Depression

EXERCISE LEVEL: __ None __ Light __ Moderate __ Heavy __ Daily

WORK ACTIVITY: __ None __ Sitting __ Standing __ High Stress Level
__ Light Labor __ Heavy Labor __ Office Work __ Computer

DO YOU: Smoke _____ Packs/Day: _____

Drink Alcohol _____ Drinks/Week: _____

Drink Coffee/Soda _____ Cups/Day: _____

Do you have a high stress level at Home or Work _____?

Are you pregnant? _____ Due Date: _____

Any **previous**: __ **Accidents/Falls** __ **Broken Bones** __ **Dislocations** __ **Surgeries**

Explain: _____

Please list the names and **reasons of any prescription or over the counter medications you are taking**:

Vitamins/Herbs/Minerals: _____

Signature: _____ **Date**: _____

Parent or Guardian (if Patient is under 18) Signature _____ Date _____



24007 Ventura Blvd. Suite 125 Calabasas, CA 91302

HIPPA FORM

Recent changes have been made concerning California health laws which provide patients with a Right to Privacy Act. Due to these changes, we are in compliance as long as you understand our office Policies and Procedures.

* We have patients sign in daily to know who has visited our office and if the insurance company wants proof we have your signature on that specific sign in sheet.

* Visit to visit - a daily travel card will be on the reception counter for the doctor to sign and in full view of our reception area.

* Examination room is private where we will perform confidential examinations, consultations and at patient's request may get adjusted in that room.

* Most of our patients that visit our office - come as referrals of current patients. As a thank you we like to acknowledge those patients on a board that states "Thank you for referring patients to our office for the best of Chiropractic care.

_____ Initials.

* Any requests of information from attorneys or doctors concerning your healthcare, we will inform you before sending information. We will not send information without having a signed consent.

Your healing experience is one of trust between you and Dr. Brian Ross. Dr. Ross looks at your health and your health concerns in the highest regard. Your personal privacy will never be violated.

If you agree to how we practice in this office, please sign and date this form below and we will keep it in our file for authorities, if requested.

Signature _____ Print Name _____ Date _____

Exam

Name _____ Date _____

Posture _____

ROM Upper

Flex _____ Ext _____ LLF _____ RTLF _____ LFRot _____ RTRot _____

Lower ROM

Flex _____ Ext _____ LLF _____ RTLF _____ LFRot _____ RTRot _____

DTR's Upper LT _____ RT _____

DTR's Lower RT _____ RT _____

MM Testing Upper LT _____ RT _____

MM Testing LT. _____ RT. _____

Rhomberg's Test _____

Orthopedic Tests

Cervical Compression _____

Shoulder Depression _____

Heel/Toe Walk _____

Leg CK Supine _____ Prone _____

SLE _____ Braggards _____ Patrick Fabrae _____

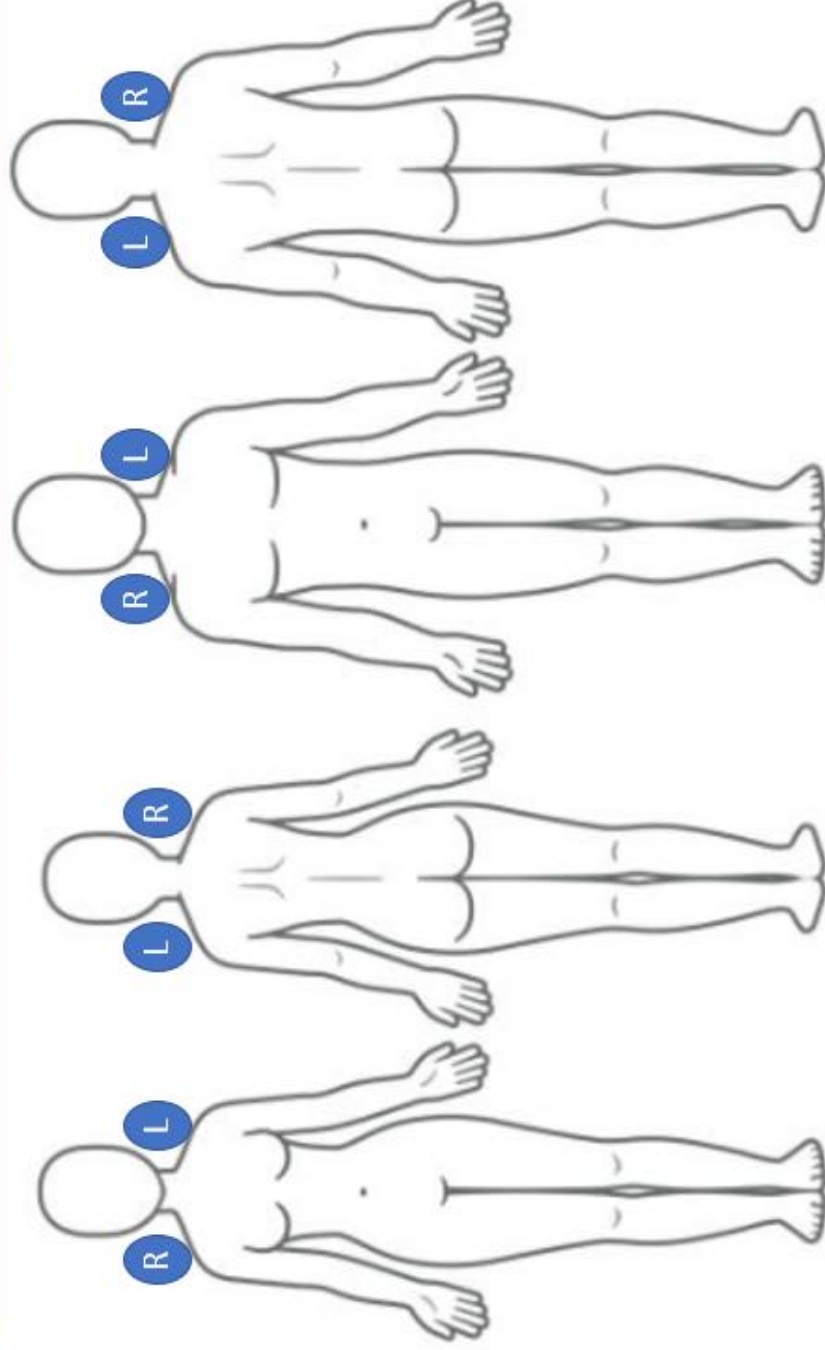
Knockclass _____ Yomens _____ Hibbs _____

Visualization _____

Palpation _____

Notes:

Body Symptom Description



Patient Name: _____

Date: _____

Level of Pain 1-10

Place an "x" where the pain is. If the pain moves draw an arrow to where it is moving.



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818-451-5700

Insurance Notification Form

Name _____

Medical ID # _____

Examinations:

In order to determine your current condition, and in order to resolve your current medical condition, the Doctor may need to do a full evaluation. I understand it is my option to cover the care that I need.

X-Rays/MRI:

The Doctor may need to order certain X-Rays and/or a specific MRI to evaluate your current condition. I understand it is my option to cover the care that I need.

Care Plan:

The Doctor may need to utilize a complex care plan. This may include modalities and/or procedures that may not be included in your current insurance plan. For example: adjustments, full spine, mechanical traction, neuromuscular re-education, therapeutic exercise, extremity adjustments, electric stim, therapeutic mobilization and manual therapy. I understand it is my option to cover the care that I need.

Patient Signature _____

Date _____

Explanation of Insurance Deductible Form

Name _____

Medical ID # _____

Your current insurance policy has a deductible which is still outstanding on your policy. This means that the insurance company will not reimburse our office for any professional services rendered. We will take care of the deductible as we go along and when your deductible has been completed, then your insurance carrier will start to reimburse us, and we will let you know when that day happens.

Patient Signature: _____

Date: _____

Insurance Carrier: _____