Dr. Todd B. Andrews D.C.
1501 N. Placentia Ave.
Placentia, CA 92870
(714) 572-3834

Date_____

PLEASE PRINT

PATIENT INFORMATION

Name_____
Address_____
City_____ Zip_____
Birth Date_____ Sex M F
Home Phone #_____
Cellular Phone #_____
Email Address_____
Social Security #_____
Marital Status_____
Referred By_____

RESPONSIBLE PARTY INFORMATION

(if other than self)
Name_____
Relationship to Patient_____
DOB_____
Home Phone #_____
Cellular Phone #_____
Work Phone #_____
Address_____
City_____ Zip_____
Employer's Name_____
Address_____
City_____ Zip_____
Occupation_____
If patient is a child, name of other parent
_____
Address_____
City_____ Zip_____
Home Phone #_____
Work #_____

EMPLOYER INFORMATION

Occupation_____
Employer_____
Employer Address_____
City_____ Zip_____
Business Phone #_____ext._____

REASON FOR CONSULTATION

What are your present complaints and symptoms?
_____
_____
Is your condition a result of a: Work injury?_____
Auto accident?_____
Other_____
Date of injury or onset_____
Family Physician_____
Phone #_____

INSURANCE INFORMATION

Are you insured? Y N
(Please present insurance card to receptionist)
Insurance Company_____
Other Insurance Company_____

EMERGENCY CONTACT

Name_____
Relationship_____
Phone #_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of benefits be made directly to this healthcare provider and I understand that I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed_____ Date_____
(Insured Person)

CONSENT TO TREATMENT OF A MINOR

I (we) being the parent or guardian of the above patient, a minor, the age of _____, do hereby consent, authorize and request this healthcare provider and whomever they may designate as their assistant, to administer such treatment deemed advisable, necessary or requested for this minor.

Signed_____ Date_____
(Parent or Legal Guardian)

TODD B. ANDREWS, D.C.
1501 N. Placentia Ave.
Placentia, Ca 92870
(714) 572-3834

GROUP INSURANCE FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available.

In order to familiarize you with the financial policies of our office, we would first like to explain how your medical bills will be handled.

We require that each patient contact their insurance company as quickly as possible to obtain their benefits. Most insurance policies cover chiropractic care, but this office makes no representation that yours does. Policies differ greatly in terms of deductibles and percentages of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require the patient to be personally responsible for the payment of deductibles and any unpaid balances. If the patient does not obtain their insurance benefits, they will be responsible to pay at the time of each visit and then they can submit their claims on their own and pursue reimbursement by the insurance company.

We do require that you pay _____% of your charges (representing your deductible and/or personal responsibility) on a per visit basis, unless other prior arrangements are made with our business office. Our office policy is that a patient's personal responsibility for outstanding charges not exceed $300.00. If it does exceed that amount, treatment may be suspended until the balance is taken care of.

If necessary, a staff radiologist will view x-rays taken in our office and give a detailed written report. Please be advised that unless paid at the time service is provided the charges for this service will be billed directly to your insurance company.

After a period of ninety days, any unpaid balances will be considered past due and will be subject to a 1.5% per month interest charge.

Please make sure that you sign the "ASSIGNMENT OF BENEFITS" portion of your history form. This instructs your insurance company to make payments directly to this office.

In order to open a claim with your insurance company, we will need at least one of your insurance company's ORIGINAL CLAIM FORMS. You should be able to get this from your employer of the insurance company directly. Also, if your insurance company requires medical reports to document your progress, your signature authorizes the release of medical information to process your claim. It is also understood that if medical bills are necessary to document your treatment and progress, a separate charge will be incurred and added to your statement for services rendered.

I have read and agree to the above.

_____ _____

Patient's Signature *Date*

Personal Health History

Name_____ **Date:**_____

INJURIES & ACCIDENTS:

Type of Accident	Date(s)
❒ Auto	_____
❒ Work	_____
❒ Fracture	_____
❒ Dislocation	_____
❒ Concussion	_____
❒ Other	_____

_____
_____

SURGERIES:

Type of Surgery

❒ Appendix ❒ Gall Bladder ❒ Hernia
❒ Hysterectomy ❒ Kidney ❒ Mastectomy
❒ Tonsils ❒ Other_____

ILLNESS:

❒ AIDS ❒ Anemia ❒ Arthritis
❒ Asthma ❒ Blindness ❒ Bronchitis
❒ Cancer ❒ Cataracts ❒ Chicken Pox
❒ Cirrhosis ❒ Colitis ❒ Depression
❒ Diabetes ❒ Duodenal Ulcer ❒ Emphysema
❒ Enlarged Heart ❒ Epilepsy ❒ Gallstones
❒ Gastritis ❒ Glaucoma ❒ Goiter
❒ Gonorrhea ❒ Gout ❒ Hay Fever
❒ Heart Disease ❒ Hepatitis ❒ Hernia
❒ HIV ❒ Jaundice ❒ Malaria
❒ Kidney Stones ❒ Measles ❒ Mumps
❒ Mononucleosis ❒ Nephritis ❒ Paralysis
❒ Phlebitis ❒ Pleurisy ❒ Pneumonia
❒ Polio ❒ Psoriasis ❒ Scarlet Fever
❒ Syphilis ❒ Hyperthyroid ❒ Hypothyroid
❒ Low B.P. ❒ High B. P. ❒ High Triglycerides
❒ High Cholesterol ❒ Tuberculosis
❒ Rheumatic Fever
❒ Other _____
❒ Other _____
❒ Other _____

PSYCHIATRIC:

_____
_____

ALLERGIES:

❒ None ❒ Aspirin ❒ Cats
❒ Foods ❒ Codeine ❒ Dust
❒ Penicillin ❒ Pollen
❒ Other _____

HAVE YOU EVER BEEN DISABLED?

❒ Yes ❒ No Date(s) _____

MEDICATION NOW TAKING: _____

_____

MARITAL STATUS:

❒ Single ❒ Married ❒ Separated
❒ Divorced ❒ Widowed

NUMBER OF CHILDREN:_____

EDUCATION:

Last grade level completed_____

FAMILY MEDICAL HISTORY:

Please identify illnesses within your immediate family

❒ Arthritis ❒ Cancer ❒ Diabetes
❒ Emphysema ❒ Epilepsy ❒ Hypertension
❒ Heart Disease ❒ Migraines ❒ Obesity
❒ Peptic Ulcer ❒ Renal Disease ❒ Rheumatic Fever
❒ Strokes ❒ Tuberculosis ❒ Rheumatoid Arthritis

Additional: _____

_____

HOBBIES:

_____
_____

GENERAL INFORMATION:

Height: Feet_____ Inches_____ Weight_____

Do you consider yourself…

❒ Alert ❒ Calm ❒ Nervous
❒ Irritable ❒ Depressed ❒ Fatigued
❒ Run Down

Do you suffer from loss of sleep? ❒ Yes ❒ No
Do you smoke or use tobacco? ❒ Yes ❒ No
Do you drink alcoholic beverages? ❒ Yes ❒ No
Do you drink caffeinated beverages? ❒ Yes ❒ No

Do you consider yourself…

❒ Well Developed ❒ Average Developed
❒ Under Developed ❒ Well Nourished
❒ Average Nourished ❒ Under Nourished
❒ Large Build ❒ Medium Build
❒ Small Build

WOMEN ONLY:

Are you pregnant at this time? ❒ Yes ❒ No
Date of last period _____
Date of last breast exam _____
Date of last pap smear _____
Do you experience…

❒ Menstrual pain ❒ Cramping ❒ Irregularity

MEN ONLY:

Date of last prostate exam_____

_____

PATIENT SIGNATURE

Name_____

HISTORY OF SYMPTOMS

Date_____

SYMPTOMS

HEAD:
- ❒ Headache
  - ❒ Entire head
  - ❒ Back of head
  - ❒ Forehead
  - ❒ Right temple
  - ❒ Left temple
  - ❒ Migraine
- ❒ Head feels heavy
- ❒ Loss of memory
- ❒ Light-headedness
- ❒ Fainting
- ❒ Light bother eyes
- ❒ Loss of balance
- ❒ Loss of smell
- ❒ Loss of taste
- ❒ Dizziness
- ❒ Loss of hearing
- ❒ Pain in ears
- ❒ Ringing in ears
- ❒ Buzzing in ears

NECK:
- ❒ Pain in neck
  Neck pain is worse when I:
  - ❒ bend forward ❒ bend left
  - ❒ bend backward ❒ bend right
  - ❒ turn right ❒ turn left
- ❒ Sensation of a pinched nerve
- ❒ Neck feels out of place
- ❒ Neck feels stiff
- ❒ Muscle spasms in neck
- ❒ Grinding or grating sounds in neck
- ❒ Popping sounds in the neck
- ❒ Arthritis in the neck

SHOULDERS:
- ❒ Pain in shoulder joint R L
- ❒ Pain across shoulders
- ❒ Bursitis R L
- ❒ Arthritis R L
- ❒ Can't raise arm:
  - ❒ above shoulder level
  - ❒ over head
- ❒ Tension in shoulders
- ❒ Pinched nerve in the shoulder R L
- ❒ Muscle spasms in shoulders

ARMS & HANDS
- ❒ Pain in upper arm R L
- ❒ Pain in forearm R L
- ❒ Pain in hand R L
- ❒ Pain in wrist R L
- ❒ Finger pain R L
- ❒ Pinched nerve in arm R L
- ❒ Pinched nerve in finger R L
- ❒ Sensation of pins and needles in arms R L
- ❒ Fingers go to sleep R L
- ❒ Hands feel cold R L
- ❒ Swollen joints in fingers R L

MID-BACK
- ❒ Mid-back pain
- ❒ Mid-back pain is worse when I :
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ turn left ❒ turn right
- ❒ Pain between shoulder blades
- ❒ Sharp stabbing pain
- ❒ Muscle spasms

CHEST:
- ❒ Chest pain
- ❒ Shortness of breath
- ❒ Pain around ribs
- ❒ Asthma
- ❒ Cough

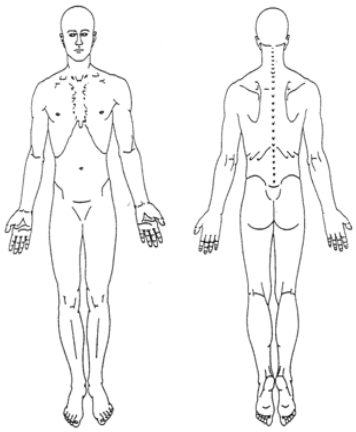
ABDOMEN:
- ❒ Nervous stomach
- ❒ Nausea
- ❒ Gas
- ❒ Constipation
- ❒ Diarrhea

LOW BACK
- ❒ Low back pain
- ❒ Low back pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Pinched nerve in low back
- ❒ Low back feels out of place
- ❒ Tailbone pain
- ❒ Tailbone pain is worse when I:
  - ❒ bend left ❒ bend right
  - ❒ twist left ❒ twist right
  - ❒ lift ❒ cough
  - ❒ sneeze ❒ stoop
  - ❒ work ❒ walk
  - ❒ bowel movements
- ❒ Muscle spasms low back
- ❒ Arthritis in low back

HIPS, LEGS, & FEET:
- ❒ Pain in buttocks R L
- ❒ Buttock pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift

HIPS, LEGS & FEET CONT.
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Pain in hip joints R L
- ❒ Hip joint pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Pain down legs R L
- ❒ Leg pain is worse when I:
  - ❒ bend forward
  - ❒ bend backward
  - ❒ bend right ❒ bend left
  - ❒ twist left ❒ twist right
  - ❒ walk ❒ sit
  - ❒ stand ❒ lift
  - ❒ cough ❒ sneeze
  - ❒ stoop ❒ work
  - ❒ bowel movements
- ❒ Leg cramps R L
- ❒ Sensation of pins and needles in legs R L
- ❒ Numbness in feet R L
- ❒ Numbness in legs R L
- ❒ Numbness in toes R L
- ❒ Feet feel cold R L
- ❒ Cramps in feet R L
- ❒ Swollen ankles R L
- ❒ Swollen feet R L
- ❒ Painful joints in toes R L

PLEASE MARK AN "X" WHERE YOU FEEL PAIN, TINGLING, OR NUMBNESS.



_____
Patient Signature

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health Insurance Company (or Companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For you security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

JM04

_____

Signature of Patient

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries in the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks of complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, is/are in my best interest.

I have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ❒ or have had read to me ❒ the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name and Address of Treating Doctor and or Clinic

Todd B. Andrews D.C.
1501 N. Placentia Ave.
Placentia, CA 92870
(714) 572-3834

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative (if minor or incapacitated) Date

_____ _____
Witness to Patient's Signature Date

_____ _____
Translated By Date

Insurance Patient Informed Consent

Informed notification that insurance patients may receive payment from insurance company in the mail. If this occurs, patients will submit all insurance checks to Dr. Todd B. Andrews' Office. Furthermore, the patient understands that they will initially be responsible for paying the full treatment price until after insurance has been billed and has paid for patient's treatment.

_____ _____

Patient Signature Date

** All United Health Care members require prior authorization for treatment.

_____ _____

Patient Signature Date

Non Covered Expense Informed Consent

Informed notification that the laser therapy that Todd B. Andrews, D.C uses is not a covered expense. The patient understands that they are responsible to pay for their therapy.

_____ _____

Patient Signature Date