

# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.  
 All information you supply is confidential. We comply with all federal privacy standards.  
 Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

No  Yes

When?

If so, whom?

Age  
 Gender  Male  Female

Race  
 American Indian  Alaskan Native  Asian  Black or African American  
 Native Hawaiian  Other Pacific Islander  Other  White  
 Decline to answer

Ethnicity  
 Hispanic or Latino  
 Not Hispanic or Latino  
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker  Former Smoker  
 Current Every Day Smoker  Current Some Day Smoker  
 Heavy Smoker  Light Smoker

Your First Name

Your Middle Name

Address

Marital Status  Married  
 Single  Divorced  
 Widowed  Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Cell Phone Carrier

Spouse's Name

Email Address

Emergency Contact

Emergency Contact's Phone

Relationship to Emergency Contact

Your Occupation

Your Employer

Work Phone

Address

May we contact you at work?

Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone  
 Work Phone  Email

Primary Care Provider's Name

Insurance Carrier

Policy Number and Claim Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

**Primary Complaint**

The primary symptom that prompted me to seek care today is: \_\_\_\_\_

\_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

Rate your pain using a scale of 0 - 10

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  
 Mild-----Moderate-----Severe

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Secondary Complaint**

The secondary symptom that prompted me to seek care today is: \_\_\_\_\_

\_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

Rate your pain using a scale of 0 - 10

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  
 Mild-----Moderate-----Severe

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Additional Complaint**

The additional symptom that prompted me to seek care today is: \_\_\_\_\_

\_\_\_\_\_

**And are the result of (darken circle):**

- An accident or injury  
 Work  Auto  Other \_\_\_\_\_

Rate your pain using a scale of 0 - 10

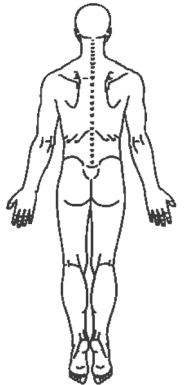
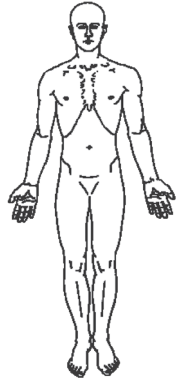
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  
 Mild-----Moderate-----Severe

**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Acupuncture  
 Over-the-counter drugs  Chiropractic  
 Homeopathic remedies  Massage  
 Physical therapy  Ice  
 Surgery  Heat  
 Other \_\_\_\_\_

**Location**  
 (Where does it hurt?)  
 Circle the area(s) on the illustration.  
 "O" for current condition  
 "X" for conditions experienced in the past



1. What else should Dr. Meininger know about your current condition? \_\_\_\_\_

2. How does your current condition interfere with your:

Work or career: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Household responsibilities: \_\_\_\_\_

Personal relationships: \_\_\_\_\_

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis                   | <input type="radio"/> Arthritis                      | <input type="radio"/> Scoliosis                      | <input type="radio"/> Neck pain                      | <input type="radio"/> Back problems                  | <input type="radio"/> Hip disorders                  | Initials _____             |
| <input type="radio"/> Knee injuries                  | <input type="radio"/> Foot/ankle pain                | <input type="radio"/> Shoulder problems              | <input type="radio"/> Elbow/wrist pain               | <input type="radio"/> TMJ issues                     | <input type="radio"/> Poor posture                   |                            |

b. Neurological

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety                        | <input type="radio"/> Depression                     | <input type="radio"/> Headache                       | <input type="radio"/> Dizziness                      | <input type="radio"/> Pins and needles               | <input type="radio"/> Numbness                       | Initials _____             |

c. Cardiovascular

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure            | <input type="radio"/> Low blood pressure             | <input type="radio"/> High cholesterol               | <input type="radio"/> Poor circulation               | <input type="radio"/> Angina                         | <input type="radio"/> Excessive bruising             | Initials _____             |

d. Respiratory

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma                         | <input type="radio"/> Apnea                          | <input type="radio"/> Emphysema                      | <input type="radio"/> Hay fever                      | <input type="radio"/> Shortness of breath            | <input type="radio"/> Pneumonia                      | Initials _____             |

e. Digestive

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia               | <input type="radio"/> Ulcer                          | <input type="radio"/> Food sensitivities             | <input type="radio"/> Heartburn                      | <input type="radio"/> Constipation                   | <input type="radio"/> Diarrhea                       | Initials _____             |

f. Sensory

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision                 | <input type="radio"/> Ringing in ears                | <input type="radio"/> Hearing loss                   | <input type="radio"/> Chronic ear infection          | <input type="radio"/> Loss of smell                  | <input type="radio"/> Loss of taste                  | Initials _____             |

g. Skin

- |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer                    | <input type="radio"/> Psoriasis                      | <input type="radio"/> Eczema                         | <input type="radio"/> Acne                           | <input type="radio"/> Hair loss                      | <input type="radio"/> Rash                           | Initials _____             |

\_\_\_\_\_  
**Patient name**

\_\_\_\_\_  
**Patient Number**  
 (office use only)

\_\_\_\_\_  
**Doctor's Initials**

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 National Registry of Certified Medical Examiners

(Continued from previous page)

**h. Endocrine**

- Had  Have  Thyroid issues    Had  Have  Immune disorders    Had  Have  Hypoglycemia    Had  Have  Frequent infection    Had  Have  Swollen glands    Had  Have  Low energy    NONE

Initials \_\_\_\_\_

**i. Genitourinary**

- Had  Have  Kidney stones    Had  Have  Infertility    Had  Have  Bedwetting    Had  Have  Prostate issues    Had  Have  Erectile dysfunction    Had  Have  PMS symptoms    NONE

Initials \_\_\_\_\_

**j. Constitutional**

- Had  Have  Fainting    Had  Have  Low libido    Had  Have  Poor appetite    Had  Have  Fatigue    Had  Have  Sudden weight gain/loss (circle one)    Had  Have  Weakness    NONE

Initials \_\_\_\_\_

Patient name \_\_\_\_\_

Patient Number (office use only) \_\_\_\_\_

All other systems negative

**Past Personal, Family and Social History**

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

<b>PERSONAL</b>	<b>4. Illnesses</b> Check the illnesses you have <b>Had</b> in the past or <b>Have</b> now.	<b>5. Operations</b> Surgical interventions, which may or may not have included hospitalization.	<b>6. Treatments</b> Check the ones you've received in the <b>Past</b> or are receiving <b>Currently</b> .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	<b>Past</b> <input type="radio"/> <b>Currently</b> <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	Had <input type="radio"/> Have <input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	Had <input type="radio"/> Have <input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	Had <input type="radio"/> Have <input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer		<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox		<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes	<b>7. Allergies</b> Are you allergic to any medications?	<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy	Yes <input type="radio"/> No <input type="radio"/> If Yes please list: _____	<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma		<input type="radio"/> Homeopathy
	Had <input type="radio"/> Have <input type="radio"/> Goiter		<input type="radio"/> Hormone replacement
	Had <input type="radio"/> Have <input type="radio"/> Gout		<input type="radio"/> Inhaler
	Had <input type="radio"/> Have <input type="radio"/> Heart disease		<input type="radio"/> Massage therapy
	Had <input type="radio"/> Have <input type="radio"/> Hepatitis		<input type="radio"/> Physical therapy
	Had <input type="radio"/> Have <input type="radio"/> HIV Positive		<input type="radio"/> Medications
Had <input type="radio"/> Have <input type="radio"/> Malaria		(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____	
Had <input type="radio"/> Have <input type="radio"/> Measles			
Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis			
Had <input type="radio"/> Have <input type="radio"/> Mumps			
Had <input type="radio"/> Have <input type="radio"/> Polio	<b>8. Injuries</b> Have you ever...		
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing	
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo	
Had <input type="radio"/> Have <input type="radio"/> Stroke	<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing	

Consultation Notes

**9. Family History**

Some health issues are hereditary. Tell Dr. Meininger about the health of your immediate family members.

	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
<b>FAMILY</b>	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

**10. Are there any other hereditary health issues that you know about?** \_\_\_\_\_

**11. Social History**

Tell Dr. Meininger about your health habits and stress levels.

<b>SOCIAL</b>	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials \_\_\_\_\_

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National Registry of Certified Medical Examiners

**12. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name \_\_\_\_\_

Patient Number  
(office use only)

13. What is the major stressor in your life? \_\_\_\_\_ 14. How much sleep do you average per night? \_\_\_\_\_ Hours

15. What is the type and approximate age of your mattress and pillow? \_\_\_\_\_ 16. What is your preferred sleeping position? \_\_\_\_\_

17. Describe your typical eating habits:  Skip breakfast  Two meals a day  Three meals a day  Snacking between meals

18. What would be the most significant thing that you could do to improve your health? \_\_\_\_\_

19. In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

20. What is your Height? \_\_\_\_\_ What is your Weight? \_\_\_\_\_

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials \_\_\_\_\_ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials \_\_\_\_\_ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials \_\_\_\_\_ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_

Initials \_\_\_\_\_ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, unencrypted emails or personal health information to me or to an authorized recipient as an extension of my care in this office.

Initials \_\_\_\_\_ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials \_\_\_\_\_ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Consultation Notes

Doctor's Initials

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National Registry of Certified Medical Examiners

\_\_\_\_\_  
Patient (or Guardian's) signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

# VEHICLE ACCIDENT INFORMATION

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_  a.m.  
 p.m.

Please describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian How many people were in the accident vehicle? \_\_\_\_\_

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_

City/State \_\_\_\_\_

Nearest intersection with road/street \_\_\_\_\_

Driving conditions  Dry  Wet  Icy  Other \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_

Speed you were traveling? \_\_\_\_\_

## IMPACT

Did your car impact another vehicle?  Yes  No

Did your car impact a structure?  Yes  No

If yes, explain \_\_\_\_\_  
\_\_\_\_\_

Did any part of your body strike anything in the vehicle?

Yes  No If yes, explain \_\_\_\_\_

Was impact from :

Front  Rear  Left  Right  Other \_\_\_\_\_

At the time of impact were you:

Looking straight ahead  Looking to the right

Looking to the left  Looking down

Looking up

Were both hands on the steering wheel?  Yes  No

If no, which hand was on the wheel?  Right  Left

Was your foot on the brake?  Yes  No

If yes, which foot was on the brake?  Right  Left

Were you:  Surprised by impact  Braced for impact

## VEHICLE

Make and model of vehicle you were in:  
License Plate or TAG# \_\_\_\_\_

Were you wearing a seatbelt?  Yes  No  
If yes, what type?  Lap  Shoulder

Was vehicle equipped with airbags?  Yes  No  
If yes, did it/they inflate properly?  Yes  No

Did your seat have a headrest?  Yes  No  
If yes, what was the position of the headrest?  
 Low  Midposition  High

## OTHER VEHICLE

(if applicable)

Make and model of other vehicle \_\_\_\_\_

Which direction was other vehicle headed? \_\_\_\_\_

Speed other vehicle was traveling \_\_\_\_\_

## POLICE

Did the police come to the accident site?  Yes  No

Were there any witnesses?  Yes  No

Was a police report filed?  Yes  No

Was a traffic violation issued?  Yes  No

If yes, to whom? \_\_\_\_\_

## PATIENT CONDITION

Were you unconscious immediately after the accident?  Yes  No If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident:

\_\_\_\_\_  
\_\_\_\_\_

## TREATMENT

Did you go to the hospital?  Yes  No

When did you go?  Immediately after accident  Next day  2 days or more after the accident

How did you get to the hospital?  Ambulance  Private transportation

Name of hospital \_\_\_\_\_ Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment received \_\_\_\_\_

X-rays taken \_\_\_\_\_

## SYMPTOMS/INJURIES

Have you been able to work since this injury?  Yes  No How many work days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No

If you have had any of the following symptoms since your injury, please  check:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff          |
| <input type="checkbox"/> Back stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear buzzing       | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear ringing       | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Vision blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

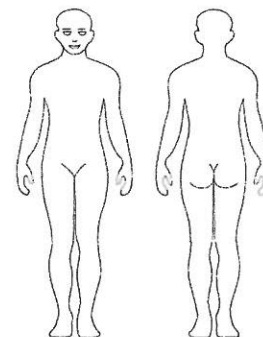
Type of pain:  Sharp  Dull  Throbbing  Numbness  
 Aching  Shooting  Burning  Tingling  
 Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Movements that are painful to perform:  Sitting  Standing  Walking  
 Bending  Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

# **Neck Index**

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## **Sleeping**

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## **Reading**

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## **Concentration**

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## **Work**

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## **Personal Care**

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## **Driving**

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## **Recreation**

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## **Headaches**

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

\_\_\_\_\_  
**Doctor's Initials**

**MEININGER***clinic*  
MARK J. MEININGER, BS, DC, CME, CCSP®  
Whiplash Case Management, Sports Injury and Spinal Care  
National Registry of Certified Medical Examiners



# **Back Index**

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## **Sleeping**

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## **Sitting**

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## **Standing**

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## **Walking**

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## **Personal Care**

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## **Traveling**

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## **Social Life**

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## **Changing degree of pain**

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

**Doctor's Initials**

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# MEININGER*clinic*

**MARK J. MEININGER, BS, DC, CCSP**

*Whiplash Case Management, Certified Sport's Injury and Spinal Care*

*550 Hampton Rd.*

*McDonough, Georgia 30253*

*(770) 957-7881*

*Fax (770) 957-6283*

## **Informed Consent**

Chiropractic, along with other types of healthcare, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in contesting to treatment

### **Specific Risk Possibilities Associated with Chiropractic Care:**

**Stroke:** Stroke is the most serious complication of Chiropractic Treatment, and the rarest. According to the journal of CCA, vol. 37, no. 2, June 1993, recent studies estimate the risk of this type of stroke is 1 in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical treatment poses a small risk for a stroke, which could result in temporary or permanent brain dysfunction, with some extreme cases resulting in death.

**Soreness:** Chiropractic adjustments are sometimes accompanied with post treatment soreness. This is normal, but be sure to inform your doctor of Chiropractic of the soreness.

**Soft Tissue Injury:** Occasionally Chiropractic treatment may aggravate a disc injury, or cause a minor joint, ligament, tendon or other soft tissue injury.

**Rib Injury:** Manual adjustments to the thoracic spine could cause a rib injury or fracture. Keep in mind that this is very uncommon, and treatment is performed very carefully to minimize such risk. Precautions such as pre-adjustment X-rays are taken and thoroughly analyzed in cases that are considered at risk of such injury.

**Physical Therapy Burns:** Heat generated by physical therapy modalities can cause minor burns to the skin. Burns that are serious are very unlikely, but should be reported, as well, as other side effects you may be experiencing.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, condition or disease. An attempt to provide the best Chiropractic care is our goal, and if the results are not successful, we will kindly refer you to another health care provider. If you have any questions, please ask your doctor.

**Having carefully read the above, I hereby give my informed consent to have Chiropractic treatment administered.**

\_\_\_\_\_  
**Patient's Printed Name**

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Parent or Guardian**

\_\_\_\_\_  
**Doctor's Initials**

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## ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

**THIS ASSIGNMENT, LIEN, RELEASE, AND POWER OF ATTORNEY (hereinafter the "Agreement"), is entered into this \_\_\_\_ Day of \_\_\_\_\_, 20\_\_ between \_\_\_\_\_ hereinafter "Patient" and Dr. Mark J. Meininger PC.**

**WHEREAS** Patient desires to receive chiropractic services from Dr. Mark J. Meininger PC and desires to assign certain rights and benefits to Dr. Mark J. Meininger PC for such benefits.

Accordingly, Patient hereby enters into this contract and consents to and agrees to the following provisions:

- A. Patient hereby authorizes Dr. Mark J. Meininger PC to furnish a full report and records regarding Patient's case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character to Patient's attorney and insurer(s).
- B. Patient hereby assigns to Dr. Mark J. Meininger PC any and all benefits payable by Patient's insurance plan(s), Patient's health care plan(s), and any and all benefits payable by an insurer or any other person or entity as a result of charges incurred by Patient for services rendered by Dr. Mark J. Meininger PC. Patient also assigns to Dr. Mark J. Meininger PC any and all contractual rights Patient has against insurers, health care benefit plan(s), or any other person or entity potentially liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Dr. Mark J. Meininger PC.
- C. Patient fully understands that Patient is directly and fully responsible to Dr. Mark J. Meininger PC for all bills for services rendered and that this agreement is made solely for additional protection and consideration for Dr. Mark J. Meininger PC to await payment. Patient further understands that such payment to Dr. Mark J. Meininger PC is not contingent on any settlement, claim, judgment, or verdict that Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other person or entity possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Dr. Mark J. Meininger PC, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 1% per month, plus attorney's fees, court costs and postage costs incurred by Dr. Mark J. Meininger PC.
- D. Patient fully understands that this lien and assignment given to Dr. Mark J. Meininger PC herein is irrevocable.
- E. By executing this Agreement, Patient hereby instructs and directs any attorney representing Patient to honor this Agreement and issue payment directly to **Dr. Mark J. Meininger PC, 550 Hampton Road, McDonough, Georgia 30253, telephone number (770)957-7881.** Patient directs that his/her attorney be bound by this lien and treat it, irrevocably, as an assignment due to Dr. Mark J. Meininger PC. Dr. Mark J. Meininger PC is relying upon this Agreement, and as a result of such reliance, Dr. Mark J. Meininger PC is providing care and treatment for which this Agreement provides security for payment. Moreover, Patient agrees that Dr. Mark J. Meininger PC is to be viewed as a third-party beneficiary of this direction to Patient's attorney, and it is Patient's intent to impose upon Patient's attorney(s) an obligation to comply with the terms of this directive.
- F. **Patient hereby instructs and directs all insurers and all other persons possibly liable or responsible for Patient's healthcare costs to issue payment for healthcare services rendered by Dr. Mark J. Meininger PC directly to Dr. Mark J. Meininger PC, 550 Hampton Road, McDonough, Georgia 30253, telephone number (770)957-7881.**
- G. Patient agrees that he or she has an obligation to provide a copy of this Agreement to Patient's attorney(s), insurer(s), and all other persons possibly liable or responsible for Patient's healthcare costs. Patient further agrees

Initials \_\_\_\_\_

that Dr. Mark J. Meininger PC has Patient's consent and authority to provide copies of this Agreement to any other person or entity it deems necessary.

- H. **Patient agrees that in the event Patient receives any check, draft, deposit, transfer, title, property, or other payment subject to this Agreement, Patient agrees to act as fiduciary agent for Dr. Mark J. Meininger PC and will immediately deliver said check, draft, deposit, transfer, title, property, or other payment to Dr. Mark J. Meininger PC to be applied towards Patient's debt for services rendered.**
- I. **In the event Patient's attorney or agent receives any type of check, draft, deposit, transfer, title, property, or other payment subject to this Agreement, Patient hereby instructs and directs his/her attorney to pay Dr. Mark J. Meininger PC in full for Patient's debt for services rendered.**
- J. Patient hereby appoints Dr. Mark J. Meininger PC as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third-party claims relating to services rendered to Patient by Dr. Mark J. Meininger PC. Dr. Mark J. Meininger PC is not obligated or compelled to exercise such powers but may do so in its sole discretion. Patient agrees to fully cooperate with Dr. Mark J. Meininger PC in collecting said amounts.
- K. Patient hereby authorizes Dr. Mark J. Meininger PC to receive a complete copy of Patient's insurance policy/policies, including any declarations, endorsements, conditions, limitations, or exclusions.
- L. Being that this Agreement is contractual in nature and irrevocable, it will supersede any future bankruptcy filings and proceedings, and payment will still be due.
- M. Patient agrees and understands that interest of 1% per month on any unpaid balance will begin to accrue 60 days after settlement of Patient's claim, judgment on Patient's claim, verdict on Patient's claim, or Patient's or Patient's attorney's receipt of any type of payment on Patient's claim, whichever occurs first.
- N. Patient further agrees to provide to Dr. Mark J. Meininger PC the name of the alleged tortfeasor(s) and the alleged tortfeasor's/tortfeasors' insurer(s) once known by Patient or Patient's attorney.
- O. A copy of these documents shall be as binding as the document bearing the original signatures.

\_\_\_\_\_  
Date    Patient's Signature (and Guardian if Minor)

\_\_\_\_\_  
Patient's Printed Name (and Guardian if Minor)

\_\_\_\_\_  
Date    Dr. Mark J. Meininger PC / Dr. Zakary Ryan

\_\_\_\_\_  
Date    Patient's Attorney Signature

\_\_\_\_\_  
Attorney's Printed Name

## PATIENT RESPONSIBILITY FOR PAYMENT

As a service to our patients, Dr. Mark J. Meininger PC will submit charges for chiropractic treatment to the patient's insurance company. I, hereby, authorize Dr. Mark J. Meininger, PC and/or Meininger Clinic to furnish information to my insurance carriers concerning my illness and/or treatment. I, hereby, assign to Dr. Mark J. Meininger, PC and/or Meininger Clinic all payments for chiropractic/medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Dr. Mark J. Meininger, PC and/or Meininger Clinic and the staff may attempt to verify in advance that the patient's insurance company will pay for specific chiropractic procedures. Occasionally, even though coverage was verified and an authorization may have been obtained before the chiropractic services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the chiropractic bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

I understand that if I obtain services from the chiropractor without a referral (HMO or POS) from my primary care physicians that I will be responsible for the amount that the insurance states is the responsibility of the patient.

I understand that if my insurance company forwards the check to me that I will be responsible to endorse the check to Dr. Mark J. Meininger, PC and/or Meininger Clinic immediately for services rendered at the office of Dr. Mark J. Meininger, PC and/or Meininger Clinic.

## CONTRACTUAL AGREEMENT TO PAY CHIROPRACTIC EXPENSES

I agree to pay all chiropractic/medical expenses within 30 days of the date that I am billed for those expenses, unless other arrangements have been made with Dr. Mark J. Meininger PC. I understand that if my account is not paid and is turned over to Dr. Mark J. Meininger, PC's collection agency that I will be responsible for the full amount owed, plus any legal fees, collection fees and attorney fees to Dr. Mark J. Meininger, PC.

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Patient or Patient's Guardian Signature**

\_\_\_\_\_

**Patient's Printed Name**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Dr. Mark J. Meininger PC / Dr. Zakary Ryan**

Current Employer: \_\_\_\_\_  
Address: \_\_\_\_\_

Current Insurer: \_\_\_\_\_  
Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Current Insurer Phone: \_\_\_\_\_

## HIPAA EMAIL CONSENT FORM

### **VERY IMPORTANT! PLEASE READ!**

- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Your private health Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- If we utilize email to contact you or send your records to requested and authorized locations, it is not considered to be secured, yet many patients want us to utilize this fast, convenient method, but HIPAA requires your permission.

### **PLEASE SELECT ONLY ONE OF THE OPTIONS BELOW**

(1)

#### **OPTION 1 - ALLOW UNENCRYPTED EMAIL**

I understand the risks of unencrypted email and do hereby give permission to the Dr. Mark Meininger and his staff to send my personal health information via unencrypted email to authorized recipients.

\_\_\_\_\_  
Signature  
(Parent or Guardian if Minor)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Printed Name

Print Email Address \_\_\_\_\_

*OR*

(2)

#### **OPTION 2 - DO NOT ALLOW UNENCRYPTED EMAIL**

I do not wish to have private health information sent via email.

\_\_\_\_\_  
Signature  
(Parent or Guardian if Minor)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Printed Name

# MEININGER*clinic*

**MARK J. MEININGER, BS, DC, CCSP**

*Whiplash Case Management, Certified Sport's Injury and Spinal Care*

*550 Hampton Rd.  
McDonough, Georgia 30253*

*(770) 957-7881  
Fax (770) 957-6283*

## PAYMENT INFORMATION

Who should we bill for your treatment cost? Please check one below.

Your Medical Insurance     Attorney     Your Auto insurance

The Person responsible for the Accident or     Self Pay

\*The Patient is ultimately responsible for any and all treatment cost\*

---

## PLEASE PROVIDE THE FOLLOWING INFORMATION

---

Name of Company Responsible for Payment

---

Name of Insurance Adjuster of Attorney

---

Phone Number and extension

---

Claim# or Policy #

---

Print Name

---

Date

---

Signature