NEW PATIENT INFORMATION

PATIENT

First Name_____ M.I .___Last Name _____I.D._____
Sex _____ D.O.B._____ S.S. Number _____Driver License #_____
Address: _____E-mail_____
City _____State ____ Zip _____Home/Cell Phone_____

INSURED

First Name_____ M.I .___Last Name _____I.D._____
Sex _____ D.O.B._____ S.S. Number _____
Address: _____
City _____State ____ Zip _____ Phone _____

INSURANCE

Insurance Carrier _____
Address:_____
City _____State ____ Zip _____ Phone _____

EMPLOYER

Current Employer _____
Address: _____
City _____State ____ Zip _____ Phone _____

PATIENT INFORMATION

Date of Injury _____ Time of Injury _____ Date of 1st Tx _____
Is this Injury: □ Personal Injury □ Work Comp Injury □ Private Pay □ Group Ins. □ Medicare
□ Other

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance

IN ORDER TO CONTROL YOUR COST OF BILLINGS; WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT

If this account is assigned for collection and/or suite, collection costs and/or interest, and/or court costs will be added to the total amount due.
To the extend necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans, to: _____
This assignment will remain in effect until revoked by the doctor in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment
SIGNED _____ DATE _____

RESPONSIBLE PARTY* _____ DATE _____

PLEASE READ

CALIFORNIA LAW

It is unlawful to:

1. Present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.
2. Prepare, make, or subscribe any writing with intent to present or use the same, or to allow it be presented or used in support of any such claim.

Every person who violates this law shall be punished by up to three (3) years in the State Prison, or a fine not exceeding $1,000.00,or by both

CLIENT'S DECLARATION

I, _____, declare as follows

1. I have read the above state of California Law;
2. I have signed a true adjustment of facts of my accident to an authorized representative of this office.
3. I was injured in this accident and have or will be seeking treatment for my injury (ies):
4. The parts of my body that are injured are:

    a)

    b)

    c)

I declare under penalty or perjury under the laws of the State of California that the forgoing is true and correct.

Execute this _____ day of _____20____ at _____

_____

Patient Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

To: _____ Patient:_____
Insurance Company
_____ Employer:_____

_____ Claim Group#:_____

Phone _____ Soc. Sec. #/I.D.#:_____
I hereby instruct and direct the above Insurance Company to pay by check made out and directly mailed to:

OR Eduard Burt, D.C., MUAC 15200 Hesperian Blvd., Ste. 104 San Leandro, CA. 94578

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O Eduard Burt, D.C., MUAC 15200 Hesperian Blvd., Ste. 104 San Leandro, CA. 94578

For professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original one

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_×_____ Date_____
Signature of Policyholder

_____ _____
Signature of Claimant, if other than Policyholder Witness

ACKNOWLEDGEMENT OF INSURANCE COMPANY

This insurance company hereby acknowledges receipt of the above instruction and agrees to mail payment of medical coverage benefits of the policy directly to the office of and to the order of the doctor only.

Date: _____ Authorize Signature: _____
Please date and sign one copy. Kindly return for the patient's file.

AUTOMOBILE INJURY HISTORY

Name_____ Date of accident _____Time _____

Where did accident happen? _____

Describe accident in your own words _____
_____
_____

What was your position in a car? □ Driver □ Passenger. If passenger, were you sitting in □ Front □ Right rear □ Left rear.
Did your vehicle strike other vehicle? □Yes □ No Was your car struck by other vehicle □ yes □ no
Was the impact from □ The front? □ From the right side? □ From the left side? □ From the rear?
At the time of impact were you □ Looking straight ahead? □ Looking right? □ looking left?
Were both hands on the steering wheel? □ Yes □ No Was your foot on the brake □ Yes □ No Were you braced for impact? □ Yes □ No
Where in the car were you after an accident? _____
Were you wearing seat belts? □ Yes □ No Did you strike anything in vehicle at the time of impact? □ Yes □ No
If yes specify: □ Steering wheel □ Dashboard □ Windshield □ Side door □ Arm rest □ Side window
Please state part of the body: □ Chest □ Chin □ Knee □ Shoulder □ Hand □ Head
Immediately following the accident how did you feel? _____
_____

Were you unconscious? □ Yes □ No In a daze □ Yes □ No Did you go to the hospital □ Yes □ No
If you went to a hospital, when? At time of accident □ Yes □ No Next day □ Yes □ No
How did you get to hospital? Ambulance □ Yes □ No Private transportation □ Yes □ No
Did the Ambulance attendants place you in neck collar? □ Yes □ No Splints? □ Yes □ No Brace? □ Yes □ No
Name of Hospital _____
Attended by Dr. _____ Were you X-Rayed at hospital □ Yes □ No
If so, what was the diagnosis? _____
Were you admitted to the hospital? □ Yes □ No How long did you stay? _____
What treatment was rendered?_____
Describe symptoms from the day following accident to today's date _____
_____

What recommendations were made? See own doctor? □ Yes □ No See orthopedic doctor? □ Yes □ No
Physical therapy □ Yes □ No
Before the injury were you capable of working on an equal basis with others your age? □ Yes □ No
Are your work activities restricted as a result of this accident? □ Yes □ No
If yes, give percentage of restriction: _____
Are your home activities restricted as a result of this accident □ Yes □ No
Do you have a copy of police report? □ Yes □ No If Yes, please bring a copy to our office.

Signature _____ Date _____

Burt Chiropractic
www.burtchiropractic.com

RE:

DOI

NOTICE OF DOCTOR'S LIEN

TO: Attorney

Eduard Burt, D.C., MUAC
15200 Hesperian Blvd., Ste. 104
San Leandro, CA. 94578

Ph. (510) 481-2225 Fax (866) 501-8083

RE: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved

I hereby authorize and direct you, my attorney, to pay to said doctor such sums as may be due and owing him/her for medical service rendered by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection. I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and /or interest, and/or attorney's fees, and/or court costs will be added to the total amount due.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Date:_____

Dated:_____ Patient's Signature _____

Witness: _____ Address: _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs

Dated: _____ Attorney's Signature _____

Attorney: Please date, sign and return one copy to above doctor's office at once.
Reply envelope attached.
Keep one copy for your records.

DOCTOR FILLS OUT

STANDARD EXAMINATION

Name: _____ Date: _____ File # _____

VISUAL EVALUATION:

A: Physique:	1) Slim	2) Normal	3) Muscular	4) Overweight	5) Obese
B: Carriage&Gait	1) Normal	2) Slight Difficulty	3) Moderate Difficulty	4) Severe Difficulty	
C: Distress:	1) None Apparent	2) Mild	3) Moderate	4) Severe	
D: Antalgic Position	1) Head Tilt R L	2) Neck Rot. R L	3) Lat. Bending R L	4) Trunk Rot. R L	

VITAL SIGNS:

Height_____ Weight_____lbs. Pulse_____b.p.m. Resp._____/m B/P_____/_____

REFLEXES: _____ All Normal

DEEP	LEFT	RIGHT
Biceps	1 2 3 4	1 2 3 4
Triceps	1 2 3 4	1 2 3 4
Brachiordialis	1 2 3 4	1 2 3 4
Patellar	1 2 3 4	1 2 3 4
Achilles	1 2 3 4	1 2 3 4

DYNAMOMETER TEST:

	LEFT	RIGHT	
First Try:			lbs.
Second Try:			lbs.
Third Try:			lbs.

Patient is: L R Hand Dominant, Ambidextrous

Grip Set at: 1 2 3 4 5

CIRCUMFERENTIAL MEASUREMENTS:

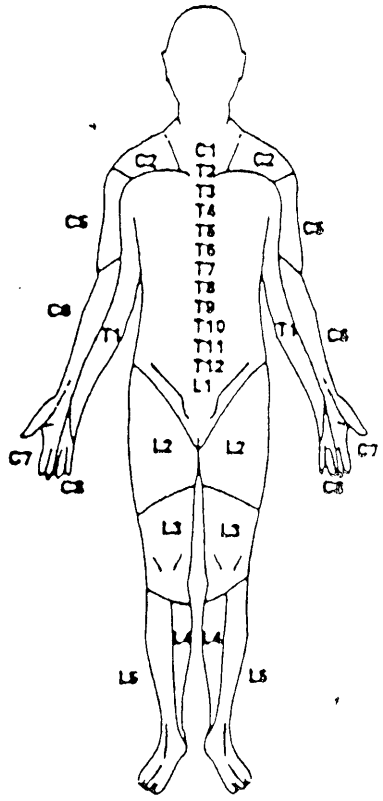
	LEFT	RIGHT	
Arm: 3" Above			in.
Forearm: 3" Below			in.
Thigh: 6" Above			in.
Calf: 6" Below			in.

NEUROLOGICAL TESTS:

	LEFT	RIGHT
Finger to Nose		
Toe Walk		
Heel Walk		
Rhomberg		

SUPERFICIAL SENSATION: _____ All Normal

	Lt.	Rt.
C1		
C2		
C3		
C4		
C5		
C6		
C7		
C8		
T1		
T2		
T3		
T4		
T5		
T6		
T7		
T8		
T9		
T10		
T11		
T12		
L1		
L2		
L3		
L4		
L5		
S1		



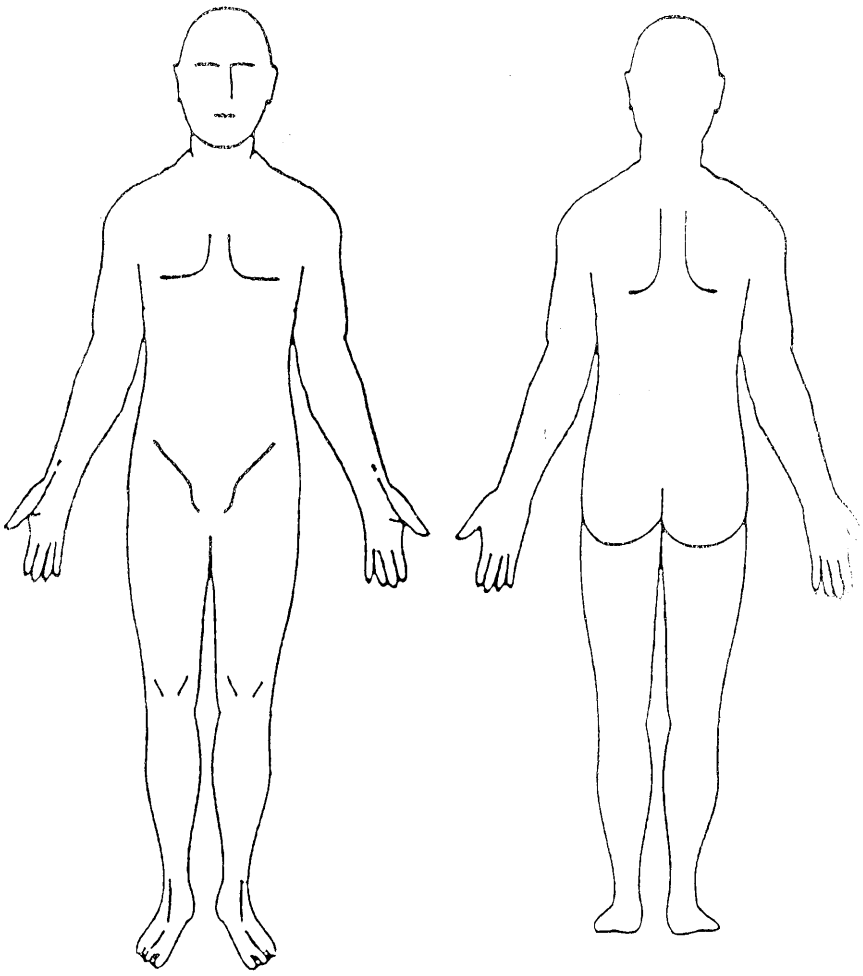
RANGES OF MOTION / ORTHOPEDIC TESTS:

Cervical ROM	Nor		Findings	Lumbar ROM	Nor		Findings
Flexion	50			Flexion	60		
Extension	60			Extension	25		
R-Lat. Flex	45			R-Lat. Flex	25		
L-Lat. Flex	45			L-Lat. Flex	25		
R-Rot	80			R-Rot			
L-Rot	80			L-Rot			

CERVICAL ORTHO	L	R	Findings	LUMBO PELVIC ORTHO	L	R	Findings
George's				Ely's			
Allen's				Kernig's			
Eden's				Patrick Faberé			
Wright's				S.L.R.			
Cerv. Com				Braggard's			
Cerv. Dist.				Dbl. S.L.R.			
Shldr. Dep.				Kemp's			
Soto Hall				Gaenslen's			
Valsalva				Burns Bench			
				Minor's Sign			

PALPATION:

	LEFT	RIGHT
Sub. Oc.		
C1		
C2		
C3		
C4		
C5		
C6		
C7		
T1		
T2		
T3		
T4		
T5		
T6		
T7		
T8		
T9		
T10		
T11		
T12		
L1		
L2		
L3		
L4		
L5		
S1		
S2		
L-SI. Joint		
R-SI. Joint		
L-Sc.Notch		
R-Sc.Notch		



T- TENDERNESS, MS- MUSCLE SPASM,
E- EDEMA, F- FIXATION

COMMENTS:

NAME _____DATE_____

1. DATE OF ACCIDENT, TRAUMA OR ONSET OF SYMPTOMS: _____
2. PLACE OF ACCIDENT, TIME:
   _____
3. DID INJURY OCCURRED AT WORK? _____
4. DESCRIBE ACCIDENT: _____

   _____

5. WERE X-RAYS TAKEN? _____

6. DID YOU RECEIVE OTHER CARE? IF YES, WHERE AND BY WHOM? _____

_____

7. DESCRIBE YOUR COMPLAIN_____

_____

_____

8. PAIN _____

   a. ONSET _____

   b. PROVOCATIVE/PALLIATIVE (WHAT MAKES IT BETTER OR WORSE) _____

_____

   I. SPECIFIC POSITIONS _____

   II. MEDICATIONS (DO THEY HELP) _____

   c. QUALITY (ex. SHARP, CUTTING, BURNING, ACHING, BORING) _____

_____

   d. REGION (PIN-POINT; WELL LOCALIZED; NOT WELL LOCALIZED) _____

   e. DOES PAIN RADIATE? _____

   f. SEVERITY (SCALE FROM 1 TO 10, WITH 10 BEING THE WORST PAIN THE PATIENT HAS EVER EXPERIENCED – ex. CHILDBIRTH, FRACTURE, KIDNEY STONES, STROKE) _____

   _____

   g. TIMING (CONTINUOUS OR INTERMITTENT, DURATION) _____

9. DISABILITY: _____