

Case History(Auto/Work)

Today's Date: _____

GENERAL INFORMATION

Patient Name: _____ Cell Phone: (____) _____ Carrier: AT&T / Sprint / _____

Home Phone: (____) _____ e-mail address or alt phone : _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: ____/____/____ Sex: Male - Female Social Security #: ____/____/____ Drivers Lic #: _____

Marital Status: S / M / D / W Which hand do you write with?: R / L / Both Ht: _____ Wt: _____ lbs. Spouse's Name: _____

Employer's Name: _____ Work Phone: (____) _____

Nature of Business/Employment: _____

Employers Address: _____ City: _____ Zip: _____

Occupation: (Job Title) _____ Length of Employment: _____ yrs. _____ mo.

Date last worked: _____ Employment Status: Full / Part / _____ Number of hours worked per week: _____ hrs/wk.

Spouse's Occupation: _____ Number of Children: _____ Ages: _____

Name of Emergency Contact: _____ Phone: (____) _____

Who or How Were You Referred to This Office: _____ Who is responsible for your account? _____

Reason / Purpose of This Appointment: _____

Other Doctors Seen for This Condition: __MD __DC __DO __DDS Names: _____

Diagnosis: _____ Other Tests: __X-rays __MRI __CT __Blood Work __Urinalysis __Other: _____

Treatment: Medications: _____ Physiotherapy: _____ Other: _____

Results: _____ Length of time under care: _____ Yrs _____ Months - Frequency of Visits: _____

Are you currently taking any medications either prescribed or over the counter: __No __Yes: _____

When Did This Condition Begin / Date of Injury: ____/____/____ Were You Disabled From Work: __NO __YES

When did your disability begin? ____/____/____ What was the last day you worked? ____/____/____

If so, how long? ____ Yrs _____ Months Have you returned to your same job? __No __Yes If yes, when? _____

SOCIAL HISTORY

Education: ____ Grade ____ Yrs. Coll List Your Hobbies and How Often You Do Them: _____

Coffee ____ cups/day Tea ____ cups/day Soda/Cokes ____ cans/day Cigarettes ____ pack/day How Many Years _____

FAMILY HISTORY

| Age | Current state of health | Living/Deceased | Age | Current state of health | Living/Deceased |
|---------------|-------------------------|-----------------|---------------|-------------------------|-----------------|
| Mother: _____ | _____ | _____ | Father: _____ | _____ | _____ |

Family History: List any conditions that your mother, father or any other relative has had which may include but is not limited to: Arthritis, Diabetes, Cancer, Heart Disease, Hypertension, Peptic Ulcer, Tuberculosis, Ankylosing Spondylitis, Multiple Sclerosis, Etc.

TURN PAGE AND CONTINUE.....

PAST MEDICAL HISTORY

Have you ever had? Sugar Diabetes Tuberculosis Heart Disease High Blood Pressure Lung Disease Intestinal Problems
 Kidney or Bladder Disease Cancer =>type:_____ Other serious Illness:_____

Have you ever had any other accidents prior to this injury, if so list dates: (including auto, sports, injuries/accidents around the home or at work, also list any broken bones):

Allergies: NONE Asprin Tetanus Toxioid Tetracycline Codine Penicillan Dusts Cats Pollen Grass Foods
 Other:_____

List all surgeries and hospitalizations from birth up to today:_____

INJURY / ACCIDENT INFORMATION

Cause of Injury: Vehicle Work Slip/Fall Sports Injury Assault Continuous Trauma Other:_____

Describe in your own words, how the accident or injury occurred:_____

What is your major complaint?_____

How long have you had this condition?_____ Have you had this or similar conditions in the past? No Yes

What activities aggravate your condition/s? Standing too long Sitting too long Lying on my back Lying on my stomach
 Driving Sneezing Coughing During sex After sex Bowel movements Pushing Pulling Bending
 Stooping Vacuuming Lifting over _____lbs. Walking long distances
Other:_____

Is this condition getting progressively worse? No Yes Constant Comes and goes Other:_____

Is this condition interfering with your: Work Daily routine Attitude Mood Sleep => it wakes me _____ times per night.

Prior to the injury I normally slept _____ hrs each night. Now after the injury I sleep _____ hrs a night. I fall asleep around _____

All Complaints / What parts of your body were injured; list area in order of severity, Intensity and Duration as follows:

Intensity of pain from 0-10; 1=Annoying and 10=Unbearable

Duration of pain, Constant= 100% of time, Frequent = 75% of time, Intermittent = 50% of time, Occasional = 25% of the time or less

Describe the quality or sensation of the pain in your own words (Ex. numbness, aching, throbbing, burning, pins & needles, stinging.)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

TURN PAGE AND CONTINUE.....

Other complaints: Difficulty chewing Insomnia Headaches Double vision Constipation Reduced hearing Weight loss
Eyes sensitive to light Nervousness Tension Lightheaded Ringing in ears Diarrhea Extreme fatigue
Reduced appetite Weight gain Weight loss Abdominal pain Dark black stool Bright red stool Coughing
Restlessness Depression Dizziness Excessive sweat Dry mouth Bloating Blurred vision Nausea
Poor memory Vomiting Difficulty swallowing Difficulty breathing Blood in urine Pain on urination
Sinus problems Menstrual irregularity Vaginal pain/infections Breast pain/lumps Prostate/Sexual dysfunction
Excessive thirst Cold extremities Ankle swelling Asthma

Other: _____

Did you lose consciousness? No Yes: Few seconds 1 minute 5 minutes 10 minutes Other: _____

Was a police report taken? No Yes Did you notify your supervisor? No Yes

How did you feel immediately after the injury? Dazed Shocked Shakey Lightheaded Jittery Scared Nervous Stunned
Confused Dizzy Nauseated Panicky Other: _____

Did you have any Fractures Cuts Abrasions Bruises If so, where: _____

Where did you develop pain immediately after the injury? _____

Did you develop pain or did the pain increase later? No Minutes later Hours later That evening The following morning
A few days later A week/weeks later A month later Months later

Where did the pain increase or where did you develop the pain? _____

Who administered care at the scene of injury? Nobody Paramedics The Police A bystander A friend/family member Doctor
Were you taken to the hospital? No Yes (How did you get there) Ambulance Family Friend Drove myself Other: _____

Hospital Name: _____ Treating Physician: _____

What was done for you at the hospital? (Write all treatment that was done and list x-rays if they were taken.)

Were you admitted? No Yes Discharge date: _____ Was medication prescribed? No Yes: _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years ago None Other: _____

Describe any previous personal injuries: _____

INJURY / ACCIDENT INFORMATION (FOR VEHICLE ACCIDENT ONLY)

How many people besides yourself were in the car? _____ => **Ages of other passengers:** _____

What type of vehicle were you driving?

Car Van Station Wagon Small Pickup Truck Full Size Pickup Motorcycle Bicycle Other: _____

Where were you seated?

Driver Right Front Middle Front Right Rear Middle Rear Left Rear Other: _____

How was your vehicle struck?

Rear-Ended Struck Head On Struck From The Right Struck From The Left Sideswiped on the LEFT RIGHT

What type of vehicle struck you?

Car Van Station Wagon Small Pickup Truck Full Size Pickup Motorcycle Bicycle Other: _____

The damage to the vehicle that you were in was: Slight Moderate Severe Totaled What was the damage amount? _____

How was the vehicle removed from the scene? I Drove the vehicle away myself Driven away by someone else Towed away

TURN PAGE AND CONTINUE.....

What was your position at the time of the accident? (Check all that apply)

I Saw The Other Vehicle Coming Unprepared Braced For The Impact Holding The Steering Wheel
 Tightly Gripping The Steering Wheel Stepping Hard On The Brakes Looking To The: Left Right Straight Ahead

How did your body move?

Forward & Backward Backward & Forward Throughout The Vehicle Outside The Vehicle Under The Vehicle
 Sideways Other: _____

How did your head move?

Sideways Forward & Backward Backward & Forward Forward Backward Other: _____

Were you wearing a seatbelt? No Yes => Type Lap Belt Only Lap & Shoulder Belt Harness Other: _____

What parts of your body struck the vehicle? (List the body part and what it struck against)

INSURANCE / ATTORNEY INFORMATION

Have you retained an Attorney? No Yes Do you have auto insurance? No Yes Do you have medical insurance? No Yes

Name of insured: _____ S.S. # of Insured: _____

Insureds Date Of Birth: ____/____/____ Insured Employers Name / Phone: _____ (____)

Insured Employers Address: _____ City: _____ State: _____ Zip: _____

Name And Address Of Insurance Carrier: _____ Agent: _____

Telephone Number of Insurance Company: (____) _____ Group #: _____ Policy / Claim #: _____

Attorney's Name: _____ Phone Number: (____) _____

Attorney's Address: _____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. If a check goes to the Doctor's Office with my name on the check, I authorize Power of Attorney to sign my name so that the check can be deposited and credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Person or Persons Assisting Patient: _____ Date: _____

Thank you!! And again, we look forward to a healthy relationship with you.

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize **Robert S. Renfro, D.C., Q.M.E.** to furnish you, my attorney, with a full report of his 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 directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my 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 for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

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 wait payment but may declare the entire balance due and payable.

Dated: _____
Patient's Signature

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 and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated: _____
Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: **Robert S. Renfro, D.C., Q.M.E.**
206 N. Euclid Street
Fullerton, CA. 92832
(714) 526-9355 Tel
(714) 526-9350 Fax

**ASSIGNMENT AND INSTRUCTION OF BENEFITS
FOR DIRECT PAYMENT TO THE DOCTOR FOR
PRIVATE / GROUP ACCIDENT AND HEALTH INSURANCE**

I hereby instruct and direct _____
Insurance Company to pay by check made out and directly mailed to:

**ROBERT S. RENFRO, D.C.
206 N. Euclid Street
Fullerton, CA. 92832-1621
(714) 526-9355 Tel (714) 526-9350 Fax**

- OR -

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: ROBERT S. RENFRO, D.C.
 206 N. Euclid Street
 Fullerton, CA. 92832-1621**

The professional or medical expense benefits allowable and other wise payable to me under my current insurance policy as payment toward charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND 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 this insurance payment.

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

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

Dated at Fullerton, CA. this _____ day of _____, 20_____.

Signature of Policyholder

Signature of Claimant, if other than Policyholder

Witness

RENFRO CHIROPRACTIC COORP.

Robert S. Renfro, D.C.

206 N. Euclid Street

Fullerton, CA. 92832

(714) 526-9355 Tel

(714) 526-9350 Fax

RE: NOTICE OF DOCTOR'S LIEN

Insured:

Claim No.:

Date of Loss:

Patient:

I do hereby authorize **Renfro Chiropractic Corp. and/or Robert S. Renfro, D.C.** to furnish you with a full report of my examination, diagnosis, treatment, prognosis, billing, etc., of myself in regard to the accident in which I was recently involved.

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

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____
Patient's Signature

Dated: _____
Doctor's Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE – “AOR”

What is HIPAA Administrative Simplification?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. In a nutshell, we are ordered to make sure all possible measures are in place in order to protect your medical information here in this office. Your medical file / information will not be given out to anyone without your consent. Other forms of protection are also implemented in order to protect your privacy as outlined in the “NOTICE OF PRIVACY PRACTICES.”

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Renfro Chiropractic’s “NOTICE OF PRIVACY PRACTICES,” revision dated April 13, 2003.

As required by the Privacy Regulations, Renfro Chiropractic has explained the “NOTICE OF PRIVACY PRACTICES,” to my satisfaction.

As required by the Privacy Regulations, I am aware that Renfro Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.

I acknowledge that I received a copy of *Renfro Chiropractic* “NOTICE OF PRIVACY PRACTICES,” revision dated April 13, 2003.

Patient name (print) _____

Signature _____ Date _____

Signed form received by: _____ Date: _____

If Patient Refuses to sign place an “X” on this line: _____

Renfro Chiropractic
206 N. Euclid St.
Fullerton, CA. 92832
714-526-9355

**INFORMED CONSENT FOR CHIROPRACTIC
TREATMENT AND CARE**

I hereby request and consent to the performance of chiropractic adjustments, massage and other chiropractic procedures, including various modes of physiotherapy including massage therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Renfro Chiropractic

I understand that, as in the practice of medicine, in the practice of chiropractic care and massage there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Renfro Chiropractic to perform such. 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.

Patient's Name (Please Print)

Date

Patient or Guardian's Signature

STOP
You Are Finished ☺
Return Forms to the Front Desk