INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist.

Today's Date: _____

Name: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

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

Age: _____ Birth Date: _____ Marital Status: S M W D Number of Children: _____

Please circle one payment type: Cash Check Master Card/Visa American Express Personal Injury Automobile Insurance Policy

Your Employer: _____ Occupation: _____ Years on Job: _____

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

Insurance Company: _____ Your Social Security #: _____

Do you have Medicare? Yes _____ No_____ Do you have Medicaid? Yes _____ No_____

Name of Spouse or Parent: _____ Their Birthdate: _____

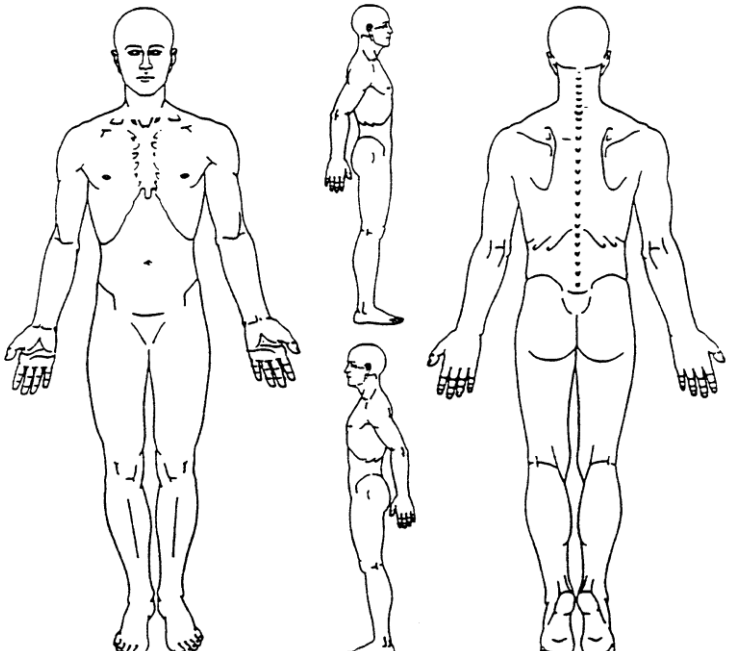
Spouse Employed By: _____ Occupation: _____ Years on Job: _____

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

Office Phone #: _____ Spouse's SS#: _____ Driver's License #: _____

Does your spouse have health insurance at work? Yes_____ No _____

COMPLETE THESE DIAGRAMS



If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

_____

_____

_____

_____

_____

Referred to our office by: _____

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident? Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____

I (we) agree to pay for service rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Or Guardian Signature: _____ Date: _____

AUTO INJURY INFORMATION

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ AM PM

Type of Accident: Auto/Traffic Work/ On Job At Home Other: _____

Describe how the accident happened in your own words: _____

_____

_____

_____

Name of Hospital/Urgent Care: _____ Attended by Dr.

_____

Were you x-rayed at the Hospital/Urgent Care? 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? _____ Prescribed medication? _____

List any other doctors you have seen as a result of this accident: _____

_____

Have you lost any time from work because of this accident? Yes____ No____ Dates: _____

Totally disabled from: _____to _____Partially disabled from: _____to _____

Have you returned to work since the accident? Yes____ No____ Were you wearing a seat belt? Yes____ No____

What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____

If auto accident, were you the: Driver_____ Passenger_____ Pedestrian_____

If passenger, were you sitting in the: Front_____ Right Rear _____ Left Rear _____ Other: _____

Did your vehicle hit other vehicle(s)? Yes____ No____ Estimated speed of your vehicle at impact? _____ MPH

Was your vehicle hit by another vehicle(s)? Yes____ No____ Estimated speed of your vehicle at impact? _____ MPH

Did your car strike the other(s) involved Yes__ No __ Or did the other car strike yours? Yes___ No___ Undetermined___

Did you require post-accident hospitalization Yes_____ No_____

VEHICLE YOU WERE IN:

Driver: _____

Insured: _____

Address: _____

Phone: _____

Auto Insurance Co: _____

Ins. co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim #: _____

OTHER VEHICLE:

Driver: _____

Insured: _____

Address: _____

Phone: _____

Auto Insurance Co: _____

Ins. co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim #: _____

AUTO INJURY INFORMATION

[ ] Headache	[ ] Irritability	[ ] Numbness In toes	[ ] Face flushed	[ ] Feet cold
[ ] Neck pain	[ ] Chest pain	[ ] Shortness of breath	[ ] Buzzing in ears	[ ] Hands cold
[ ] Neck stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of balance	[ ] Stomach upset
[ ] Sleeping problems	[ ] Head seems too heavy	[ ] Depression	[ ] Fainting spells	[ ] Constipation
[ ] Back pain	[ ] Pins & needles in Arms	[ ] Light bothers eyes	[ ] Loss of smell	[ ] Cold sweats
[ ] Nervousness	[ ] Pins & needles in Legs	[ ] Loss of memory	[ ] Loss of taste	[ ] Fever
[ ] Tension	[ ] Numbness in fingers	[ ] Ears ring	[ ] Diarrhea	[ ] _____

Symptoms other than above: _____

Name of your Insurance Company involved: _____

Name of person at your Insurance Company responsible for Injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? Yes_____ No _____

Do you have an attorney who has advised you in this case? Yes _____ No_____

Name of Attorney: _____

Address of Attorney: _____

Phone Number of Attorney: _____

Patient's Signature: _____ Date: _____

PATIENT'S NAME: _____ DATE: _____
DATE OF INJUTY / LOSS: _____

STATEMENT UNDER PENALTY OF PERJURY

PLEASE READ THIS BEFORE SIGNING, IF YOU DO NOT UNDERSTAND THIS, PLEASE ASK FOR A TRANSLATION.

ANY PERSON WHO MAKES OR CAUSES TO BE MADE KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR PURPOSES OF OBTAINING OR ACCEPTING PERSONAL INJURY BENEFITS OR PAYMENTS IS GUILTY OF A FELONY.

I HEREBY DECLARE UNDER THE PENALTY OF PERJURY THAT IN FACT I WAS INJURED DUE TO AN ACCIDENT ON THE ABOVE DATED INJURY.

I DECLARE THAT I WAS NOT PAID MONEY OR SOLICITED IN ANY WAY OR BY ANYONE TO FILE THIS CLAIM, AND THAT THE INFORMATION I AM GIVING TO MY DOCTOR (DR. DAMON SORAYA D.C, QME AT BEVERLY HILLS CHIROPRACTIC MEDICAL GROUP) AND HIS OFFICE STAFF IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

PRINTED PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE:_____

BEVERLY HILLS OFFICE
206 South Robertson Boulevard,
Beverly Hills , CA 90211
Tel: (310) 358-5568 / Fax (310) 933-0559
Chiropractor90210.com

To Attorney: _____
Re: Personal Injury Lien

Patient: _____ Date: _____

The above-named patient authorizes the above-named doctors to furnish patient's attorney or insurance company, with a full report of examination, diagnosis, course of treatment, prognosis, and any other relevant health care information in regard to the accident in which I was involved. Patient hereby authorizes and directs his/her attorney or insurance company to pay directly to the above-named doctors the full amount due for medical or administrative services rendered to benefit the patient.

This agreement is in no way relieves patient of his/her responsibility to compensate the above-named doctors for all medical and administrative costs. Patient understands and acknowledges he/she is directly and fully responsible to the above-named doctors, for any account balance, which is not contingent on the results of any third-party claim. The above-named doctors reserve the right to require regular payments on patient's account until his/her third-party claim is resolved.

Patient directs his/her attorney to promptly pay the full amount due to the above-named doctors, upon resolution of his/her claim with any third-party. Payment shall be rendered without regard to set off unresolved claims against other third-parties or apportionment or pro-rata distribution to other health care providers.

I have read and fully understand this Health Care Lien and agree to be bound by its terms.

X_____ Date: _____

Patient's Signature

Attorney agrees to observe all the terms and conditions of this Health Care Lien and withhold from any third-party, without deduction of any attorney's fees, an amount necessary to pay the outstanding account balance to the above-named doctors. Attorney agrees to promptly provide a copy of this Health Care lien to any additional or subsequent attorneys.

X_____ Date: _____

Attorney's Signature

INFORMED CONSENT

PATIENTS REQUEST FOR CHIROPRACTIC AND/OR PHYSIOTHERAPY CARE

Dear Patient, we would like to personally welcome you to our clinic. This notice is to advise you that every type of healthcare delivery system, including chiropractic care, has some associated risks and the potential for occasional problems of some kind. These problems can include temporary soreness, sprain-strain, bruising, burns, fractures, dislocations, disc injuries, stroke, etc. In considering these issues, remember that humans and their injuries are unique, and treatment that might be very effective for one person might not be as effective for another person. While we are committed to providing you with the best and safest treatment possible, we also have a legal responsibility to advise you about some very rare but potential problems that can occur with chiropractic care and/or physiotherapy. **Before you start your treatment, you need to review this information which is called your " informed consent." No treatment can begin until you have reviewed this document authorizing treatment based on your informed consent.** Please feel free to discuss any questions or concerns that you may have directly with the Doctor before any treatment at our office. **Remember, we always have time to talk with you about any concerns or questions.**

_____**Disc Herniations:** Non-surgical disc injury problems are frequently and successfully treated by skilled chiropractors. Occasionally, chiropractic treatment may aggravate a preexisting disc problem. Very rarely, chiropractic care may cause a disc problem to flare-up or even worsen, especially if the disc is already severely damaged before treatment begins.

_____**Soft Tissue Injury:** This term refers to injured muscles; tendons; ligaments; cartilage (and their attachments to bone); blood vessels; and nerves. At times, these tissues (or scar tissue) may be stretched, resulting in temporary pain.

_____**Rib Fractures:** Rarely, chiropractic adjustments may crack a rib bone. This risk is increased in elderly osteoporotic patients. We adjust all of our patients carefully, especially our older patients to minimize this risk.

_____**Burns:** Some of our physiotherapy equipment and/or modalities (hot packs, ice, ultrasound, etc.) work by generating heat or cold. Therefore, it is possible for a patient to be burned (by heat or ice) if they do not follow instructions or misuse the equipment. Usually, these are minor problems, but they can cause temporary redness, some swelling, and mild pain for a few days.

_____**Soreness:** Chiropractic adjustments, traction, massage, stretching exercises, etc., all have the possibility of making a patient sore, on a temporary basis.

_____**Stroke:** Stroke from chiropractic care is VERY uncommon. If you have a history of

If any problem starts to develop, please advise the doctor.

Disclaimer: Chiropractic is a health care delivery system, and as with any health care delivery system, we do not and can not promise or guarantee to cure any specific symptom, disease, or condition.

_____	_____	_____
Doctor's Signature	Patient's Signature	Today's Date