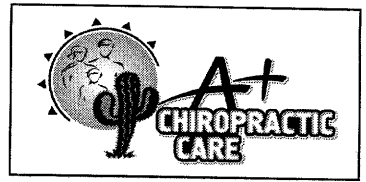


(Place Patient label here)

A Plus Chiropractic Care, PC
Howard D. Fern, DC
3048 E. Baseline Rd #130 Mesa, AZ 85204
(480)-649-5868 (fax) (480) 649-5870



CONFIDENTIAL PATIENT INFORMATION

The information requested below is strictly confidential. Please supply us with complete and accurate information. If you need assistance, please ask the front office staff.

PLEASE PRINT!

Last Name:	M.I.:	Birth Date: ____ / ____ / ____	Age
First Name:	Sex: Male Female		
Address:	Social Security # - - -		
Apt. #	Marriage Status: Single Married Divorced Widowed		
City	Drivers License #	State	
State: Zip:	E-mail Address:		
Home Phone # ()	Cell # ()		

Employment Information

Employer	Occupation
Address	Work Phone# () Ext.
City	Yrs. Employed
State Zip	Status: Full time / Part time / Retired

Insurance Information

Are you seeking care due to an automobile accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you seeking care due to an injury at work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you seeking care due to any other type of accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have health insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
At this time, please bring Your Insurance Card to the front desk so a copy may be made for your file.		
Insured Party?	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
	<input type="checkbox"/> Parent	<input type="checkbox"/> Other _____
Primary Insured Name	Primary DOB: ____ / ____ / ____	
Primary Insured Address		
Primary Insured Place of Employment		

Family Information

Name of Spouse	Spouse Employed By
Number of Children	Work Phone

Emergency

Emergency Contact Name	Telephone # ()
Relationship To You	

Whom may we thank for referring you? or How did you hear about us?

(Place Patient label here)

A Plus Chiropractic Care, PC
 Howard D. Fern, DC
 3048 E. Baseline Rd #130 Mesa, AZ 85204
 (480)-649-5868 (fax) (480) 649-5870

List your reason(s) for this visit. Place in order of importance: "what hurts the most"	When did your problem start?	On a scale of 1 to 10, "1" being no pain/discomfort and "10" being severe pain/discomfort, circle the number that best reflects your condition(s): ↓ none to severe ↓	Check the box that best represents how much time of your day you feel the pain/discomfort for the listed reason(s). ↓ Occasional to Constant ↓
1)		1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
2)		1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
3)		1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
4)		1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%

For each reason stated above, how did this problem begin?

Reason 1 _____

Reason 2 _____

Reason 3 _____

Reason 4 _____

For the reasons listed above, please circle the one(s) that best describes your current pain/symptom(s)

Reason 1: Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other _____

Reason 2: Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other _____

Reason 3: Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other _____

Reason 4: Sharp, Stabbing, Dull, Throbbing, Numbness, Burning, Aching, Shooting, Tingling, Gripping, Weakness, Other _____

For each reason listed above, What makes it feel better?

Please check the box that best describes whether your pain or symptom(s) limit normal activities

Activity	Normal	Somewhat Limited	Severely Limited	Activity	Normal	Somewhat Limited	Severely Limited
Lifting				Running			
Bending				Sleeping			
Standing				Intercourse			
Walking				Computer Work			
Sitting				Normal work			
Climbing Stairs				Household activities			
Twisting				Recreational activities			

Primary Care Physician (PCP)? _____ PCP Telephone #: () _____ - _____

Have you sought care from your PCP for this problem? Yes No

What previous treatment have you received for this condition(s)? _____

Have you sought care from anybody else? Yes No Who? _____

Have you had any tests for this problem?
 X-Ray MRI CT Scan Bone Density Body Scan Blood Testing Other: _____

Circle P = Past History, C = Current History, F = Family History to all that applies to your health history!

P C F Abdominal Pain	P C F Depression	P C F Kidney Disorders	P C F Pain in Upper Leg
P C F Angina	P C F Dizziness	P C F Kidney Stones	P C F Pain in Hip
P C F Anorexia	P C F Emphysema	P C F Liver Problems	P C F Painful Urination
P C F Aortic Aneurysm	P C F Endometriosis	P C F Gallbladder problems	P C F PMS
P C F Arthritis	P C F Epilepsy	P C F Ulcer	P C F Prostate Problems
P C F Blood Disorder	P C F Excessive Thirst	P C F Low Back Pain	P C F Rapid Heart Beat
P C F Breast Soreness	P C F Frequent Urination	P C F Mid back Pain	P C F Rheumatoid Arthritis
P C F Cancer	P C F General Fatigue	P C F Neck Pain	P C F Scoliosis
P C F Chest Pain	P C F Headache	P C F Pain in Foot	P C F Shoulder Pain
P C F Chronic Cough	P C F Heart Attack	P C F Pain in Ankle	P C F Stroke
P C F Colitis	P C F Hepatitis	P C F Pain Knee	P C F Tumor
P C F Constipation	P C F High Blood Pressure	P C F Pain in Lower Leg	P C F Loss of Bladder Control
P C F Convulsions	P C F HIV	P C F Pain in Arm	P C F Wrist Pain
P C F Diabetes I or II	P C F Jaw Pain	P C F Pain in Elbow	

List all vitamins and supplements that you currently take?

List all prescription/over the counter medication that you are currently taking? (Let us copy your list)

List all operations, hospitalization and fractures (include dates) (Let us copy your list)

Do you smoke? Yes No How Long? _____ Are you interested in becoming a non-smoker? Yes No

Are you wearing? Custom Foot Orthotics Shoe Lifts Arch Support Gel/heel insert

Do You exercise? Yes No How Often? _____ Do you have pain when exercising? Yes No

Please list anything you are allergic to:

PAIN SCALE

On the drawings below, please indicate where you are experiencing pain by placing the abbreviations that most accurately reflect the type of discomfort that you have been experiencing, at the proper location(s).

A = Dull ache

B = Burning

D = Dull pain

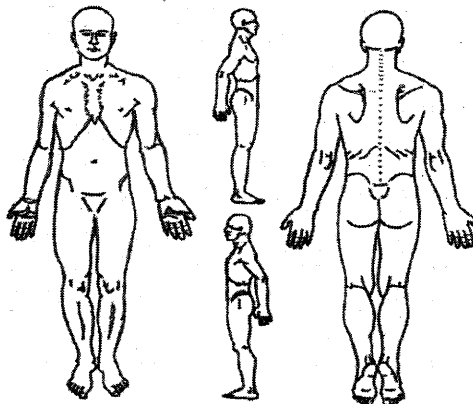
T = Tingling

N = Numbness

P = Sharp pain

S = Stiffness

O = Other



Consent To Treat

The information I have given to this office is complete to the best of my knowledge. I hold harmless, release and indemnify this clinic, its principals and employees from any liability from injury or harm that my errors or omissions within this document may have caused me or my dependents. I authorize the doctors and staff of this clinic to administer such procedures and treatment as they deem necessary. They have implied no guarantees of a cure.

Patient's signature: _____ **Date:** _____

Consent To Treat Minor Child:

The information I have given this office pertaining to _____ is truthful and complete to the best of my knowledge. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The doctors have implied no guarantee of cure.

Parent or Guardian's Signature: _____ **Date:** _____

Relationship to Minor Child: _____

Witness: _____ **Date:** _____

For Women Only:

I have been advised by the doctor or a staff member of this clinic that X-rays can be hazardous to an unborn child. At this time and to the best of my knowledge, I am not pregnant. I consent to having X-rays.

Patient's Signature: _____ **Date:** _____

Permission to use photograph and/or testimonial, or article written by patient

I consent to having my likeness and/or name reproduced for use, in a newsletter, testimonials or on the bulletin boards of this clinic. I agree that any original articles, writings, or recipes submitted can be used without compensation. I agree that for this purpose I waive the rights of privacy under the HIPAA laws.

Patient signature: _____ **Date:** _____

Authorization to Pay Directly to Doctor

TO _____
(Name of attorney and/ or insurance company)

My signature at the end of this page will act as an endorsement for this authorization. In consideration of the chiropractic services rendered and to be rendered by him, I authorize and direct the payment to Howard D. Fern, DC/ A Plus Chiropractic Care, PC of any sum I now or hereafter owe them by you, my attorney, out of the proceeds of any settlement of my case, and/ or by any insurance company obligated to reimburse me for the charges for his services otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services. If my current policy prohibits direct payments to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O A Plus Chiropractic Care
745 N. Gilbert Rd Ste 124 PMB 266
Gilbert, AZ 85234

Assignments of Benefits

I hereby authorize Howard D. Fern, DC/ A Plus Chiropractic Care, PC to furnish to the insurance company(s) listed on this form or to designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign Howard D. Fern, DC/ A Plus Chiropractic Care, PC all money to which I am entitled for medical/chiropractic expenses related to the services rendered. It is understood that money received from the above named insurance company(s) over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am fully responsible to Howard D. Fern DC/A Plus Chiropractic Care, PC for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or the court cost and reasonable legal fees should this be required. I understand that 14% annual interest fee will be added to any charges not paid after 120days. I fully understand that I am directly and fully responsible to Howard D. Fern/ A Plus Chiropractic Care, PC for all medical/chiropractic bills submitted by him for services rendered to me that this agreement is made solely for his 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.

Patient Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures we described below **we will not sell or provide any of your health information to any outside marketing organization.**

We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if/when you come in for treatment.

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Any correspondence should be addressed to:

Attn: **HIPAA Compliance Officer**
745 N. Gilbert Rd Ste 124 PMB 266
Gilbert, AZ 85234

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

1. Your Chiropractor or staff may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. Our insurance billing staff may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. Your Chiropractor or staff may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.
4. Your Chiropractor or staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. test results). 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine and/ or mailed.

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives and etc.)

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the order of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers with communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the five preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(1)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding how/ where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

INSPECTING/ COPYING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our office and/ or have a copy made for you. The health information is available up to seven years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/ or have them copied. There will be a charge of \$.50 per page copied. Copies can be made of your x-rays for a charge of \$10.00 for each film. The original film is the property of this office because we are required by law to keep it in our records. Original films can only be released on referral to another physician.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- those disclosures required for your treatment, to obtain payment for services, to run our practice,
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12 month period without any charge. For any additional requests, a fee will be charged. At the time of your request you will be notified of the cost and you will have the opportunity to withdraw or modify you request.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Written comments should be addressed to our office address at A Plus Chiropractic Care 745 N. Gilbert Rd Ste 124 Gilbert, AZ 85234 or Secretary for Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Bldg, Washington, D.C. 20201. We respect your right to file a complaint and will not take any action against you. This notice is effective as of April 14, 2003.

This notice is effective as of _____ . This notice will expire seven years after the date upon which the record was created. By Signing below, I acknowledge that I have received a copy of this notice.

Patient Name Printed

Date

Patient Signature

Authorized Provider Representative

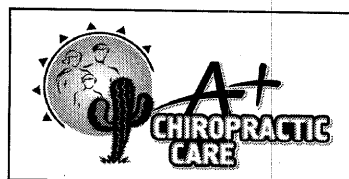
Personal Representative printed

Personal Representative Signature

Description of personal Representative's authority to act for the patient

Patient Label

A Plus Chiropractic Care, PC
Howard D. Fern, DC
3048 E. Baseline Rd #130 Mesa, AZ 85204
(480) 649-5868 Fax(480) 649-5870



Automobile Accident Questionnaire

Date of Accident: ____ / ____ /20____	Time _____	A.M. / P.M.
In your own words, please describe how the accident happened. _____ _____		
The weather at the time of the accident? (mark all that apply) <input type="checkbox"/> Sunny <input type="checkbox"/> Cloudy <input type="checkbox"/> Dark <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Raining <input type="checkbox"/> Visibility Clear <input type="checkbox"/> Visibility Poor		
What was <u>your</u> position in the vehicle? <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Rear Driver Side <input type="checkbox"/> Rear Passenger Side <input type="checkbox"/> Middle Rear <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other _____		
What type of vehicle were <u>you</u> driving? <input type="checkbox"/> Compact <input type="checkbox"/> Mid-Size Car <input type="checkbox"/> Full Size Car <input type="checkbox"/> Compact Truck <input type="checkbox"/> Full Truck <input type="checkbox"/> Mini Van <input type="checkbox"/> Full Size Van <input type="checkbox"/> Small SUV <input type="checkbox"/> Large SUV <input type="checkbox"/> Motor Home <input type="checkbox"/> Motorcycle <input type="checkbox"/> Bicycle <input type="checkbox"/> Commercial Truck <input type="checkbox"/> Other _____		
Year and model of the vehicle <u>you</u> were in?		
What was <u>your</u> vehicle doing just prior to the accident? <input type="checkbox"/> At a complete stop <input type="checkbox"/> Slowing down to a stop (braking) <input type="checkbox"/> Increasing speed <input type="checkbox"/> Merging into traffic <input type="checkbox"/> Changing lanes <input type="checkbox"/> Other _____		
Who hit who? <input type="checkbox"/> You were struck by another vehicle <input type="checkbox"/> You struck another vehicle <input type="checkbox"/> You struck a stationary object		
What was the other type of vehicle the <u>other person</u> was driving? <input type="checkbox"/> Compact <input type="checkbox"/> Mid-Size Car <input type="checkbox"/> Full Size Car <input type="checkbox"/> Compact Truck <input type="checkbox"/> Full Truck <input type="checkbox"/> Mini Van <input type="checkbox"/> Full Size Van <input type="checkbox"/> Small SUV <input type="checkbox"/> Large SUV <input type="checkbox"/> Motor Home <input type="checkbox"/> Motorcycle <input type="checkbox"/> Bicycle <input type="checkbox"/> Commercial Truck <input type="checkbox"/> Other _____		
Year and model of the <u>other</u> vehicle.		
What was <u>your</u> vehicles point of impact? <input type="checkbox"/> Front <input type="checkbox"/> Rear <input type="checkbox"/> Right Side <input type="checkbox"/> Left Side <input type="checkbox"/> Right Front <input type="checkbox"/> Left Front <input type="checkbox"/> Right Rear <input type="checkbox"/> Left Rear		
What was the <u>other</u> vehicle doing just prior to the accident? <input type="checkbox"/> At a complete stop <input type="checkbox"/> Slowing down <input type="checkbox"/> Increasing speed <input type="checkbox"/> Merging into traffic <input type="checkbox"/> Changing lanes		
What was the <u>other</u> vehicles point of impact? <input type="checkbox"/> Front <input type="checkbox"/> Rear <input type="checkbox"/> Right Side <input type="checkbox"/> Left Side <input type="checkbox"/> Right Front <input type="checkbox"/> Left Front <input type="checkbox"/> Right Rear <input type="checkbox"/> Left Rear		
Were you wearing seat restraints? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full lap & shoulder restraint <input type="checkbox"/> Lap restraint only <input type="checkbox"/> Shoulder restraint only <input type="checkbox"/> Not wearing a seatbelt		
Does your car have headrest? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, in relation to the base of your skull, where was the headrest? <input type="checkbox"/> Above the base of your skull <input type="checkbox"/> Below the base of your skull <input type="checkbox"/> Even with the base of the skull		
Does your vehicle have air bags? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, did they deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were you prepared for the impact? <input type="checkbox"/> Came as complete surprise <input type="checkbox"/> Aware and braced for collision <input type="checkbox"/> Aware but did not brace for collision		

Patient Label

A Plus Chiropractic Care, PC
Howard D. Fern, DC
3048 E. Baseline Rd #130 Mesa, AZ 85204
(480) 649-5868 Fax(480) 649-5870

What position was your head and neck in prior to the impact?

- Straight forward
- Looking down
- Rotated to the left
- Rotated to the right
- Looking in rear view mirror

What position was your body in prior to the impact?

- Straight forward
- Rotated to the right
- Rotated to the left
- Turned around

What happened to your body at the moment of impact?

- Body whipped forward/backwards
- Body was thrown from side to side
- Body torqued and twisted
- Body was tensed for impact
- Body was thrown from vehicle
- Body was pinned in vehicle
- Other _____

What was your mental/emotional state immediately following the accident?

- Rendered unconscious
- Shaken up
- Disoriented
- Shaken up & Disoriented

Did you receive medical attention at the scene of the accident? Yes No

Where did you go immediately/ soon after the accident?

- Hospital, Which one? _____
- Personal doctor, Who _____
- This office
- Home
- Resumed daily activities
- Went back to work
- Other _____

How did you get there?

- By yourself
- By Friend or Family
- By Ambulance
- By Police

Did any area of your body hit any parts inside the vehicle? Yes No

If Yes, please list the body part(s) that was hit and by what part of the vehicle.

- 1) _____ 3) _____
- 2) _____ 4) _____

If you went to the Hospital.
If you went to the doctor.

Date of visit: ____/____/20____
Date of visit: ____/____/20____

- Were you examined? Yes No
 - Were x-rays taken? Yes No
 - Were you given treatment? Yes No
 - Was medication given? Yes No
- If yes, what treatment or medication was given to you? _____

Occupation: _____ Employer: _____

Have you missed time from work? Yes No If yes, (Dates) _____ to _____

Have you been able to work since the accident? Yes No

Did the police come to the accident site? Yes No

If a traffic violation was issued, to whom was it issued? You Other driver Neither

Number of people in your vehicle? _____ Number of vehicles involved in the accident? _____

What was the approximate damage done to your car? \$ _____

Do you have an attorney on this case? Yes No
If yes, Name: _____ Telephone # (____) _____ - _____

Patient Signature _____

Date _____