DAVID L. MARTIN D.C.

KYLE R. CARPENTER B.S., D.C.

MARTIN CHIROPRACTIC

KINETIC SPORTS MEDICINE

MVA PATIENT INFORMATION

TODAY'S DATE: ________________

NAME: ________________________________ DATE OF ACCIDENT: _________________

HOME ADDRESS: _________________________________ (UNIT/SUITE/APT#): ________

CITY: ______________________________ STATE: ________ ZIP: ___________

EMAIL ADDRESS: ____________________________________ SS#: __________________

CELL PHONE#: _________________________ SEX: M_____ F_____

DATE OF BIRTH: ___________________ AGE:______ HEIGHT: _______ WEIGHT: _______

EMPLOYER: ______________________________ OCCUPATION: ___________________

EMPLOYER'S ADDRESS: ______________________________________

CITY: ______________________________ STATE: ________ ZIP: ___________

WORK PHONE: ______________________

MARITAL STATUS: M_____ S_____ W_____ D_____ NO. OF CHILDREN ________

SPOUSE'S NAME: _______________________ SPOUSE'S OCCUPATION: _____________

SPOUSE'S EMPLOYER: _______________________ WORK PHONE: ________________

IN CASE OF EMERGENCY, CONTACT: _____________________ PHONE#:_____________

WHOM MAY WE THANK FOR REFERRING YOU? _________________________________

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that MARTIN CHIROPRACTIC 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 MARTIN CHIROPRACTIC will be credited directly to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT'S SIGNATURE: ____

(If patient is a minor, parent or guardian's signature is required)

I. EXPLANATION OF THE ACCIDENT (Please check the appropriate answer)

(If your injury was not caused by an automobile accident, go to the next page, item III. NON AUTO ACCIDENT INJURY)

1. DATE OF ACCIDENT_______________ TIME OF DAY_________ AM PM

2. WERE YOU: ___DRIVING __PASSENGER __FRONT SEAT __BACK SEAT __OTHER_________________

3. WAS YOUR CAR STOPPED __YES __NO, IF STOPPED, WHY____________________ ____

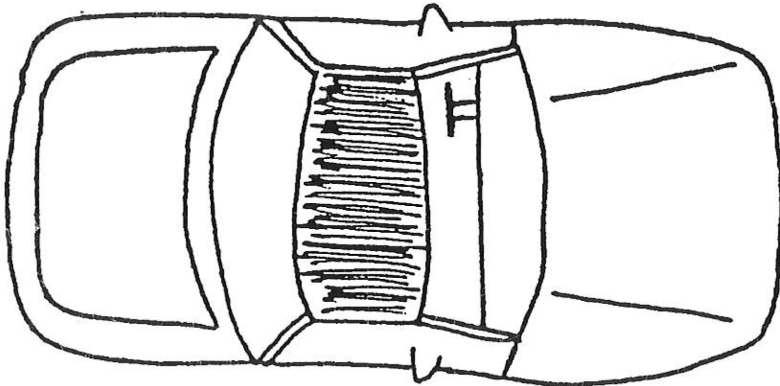
4. MAKE AND MODEL OF YOUR VEHICLE ____________________________________

5. MAKE AND MODEL OF THE OTHER VEHICLE ______________________________

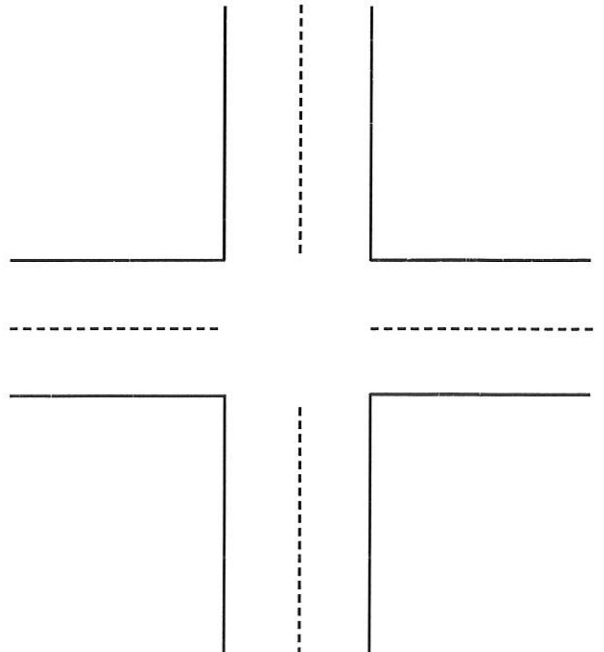
6. WHAT DIRECTION WERE YOU HEADED? __NORTH __SOUTH __EAST __WEST ON WHAT STREET?_________________________CITY?_______________________

7. WHAT DIRECTION WAS THE OTHER CAR HEADED? __NORTH __SOUTH __EAST __WEST ON WHAT STREET?_____________________________________

8. CIRCLE THE AREA YOUR CAR WAS STRUCK.



9. DRAW IN YOUR VEHICLE, THE OTHER VEHICLE, THE STREET NAMES, AND THE NORTH/SOUTH DIRECTION ARROW.



10. WERE YOU WEARING A __SEATBELT __SHOULDER HARNESS?

11. DID YOU FEEL YOUR NECK "SNAP" OR "WHIP" __FORWARD __BACKWARD __SIDE TO SIDE __NO

12. DID ANY PART OF YOUR BODY STRIKE AN OBJECT(STEERING WHEEL,DASH, ETC.)? __YES __NO. IF YES, PLEASE EXPLAIN________________________________

13. WERE YOU BRUISED? __YES __NO. IF YES, WHERE?________________________

14. WERE YOU CUT? __YES __NO IF YES, WHERE?____________________________

15. DID YOU LOSE CONSCIOUSNESS? __YES __NO IF YES, HOW LONG?__________

16. DO YOU HAVE A COPY OF THE POLICE REPORT? __YES __NO

17. IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT__________________-_

____

____

____

____

II. NON-AUTOMOBILE ACCIDENT INJURY:

18. PLEASE DESCRIBE IN YOUR OWN WORDS WHAT CAUSED YOUR INJURY (only fill in if you were not involved in an auto accident).

____

____

____

____

III. PREVIOUS TREATMENT FOR THIS INJURY:

19. WERE YOU EXAMINED AND/OR TREATED IN AN EMERGENCY ROOM? __YES __NO IF YES, WHERE?_________________________

20. HOW WERE YOU TRANSPORTED TO THE EMERGENCY ROOM? __AMBULANCE __SELF __FRIEND __OTHER

21. WERE X-RAYS TAKEN IN THE EMERGENCY ROOM? __YES __NO IF YES, WHAT PART OF YOUR BODY WAS X-RAYED?_____________________

22. WHAT TREATMENT WAS PERFORMED?_______________________________

23. WHAT MEDICATION WAS PRESCRIBED?_____________________________

24. WERE YOU HOSPITALIZED? __YES __NO IF YES, FOR HOW LONG?__________

25. LIST OTHER DOCTORS THAT HAVE EXAMINED AND/OR TREATED YOU FOR THIS INJURY (OTHER THAN EMERGENCY ROOM) AND APPROXIMATE DATES.________________

____

____

____

IV. EXPLANATION OF YOUR CONDITION:

PHYSICAL COMPLAINTS: (Please check only the ones that apply)

1. ___ HEADACHES?
2. ___ NECK PAIN OR STIFFNESS?
3. ___ SORE THROAT?
4. ___ SHOULDER PAIN OR STIFFNESS?
5. ___ JAW PAIN? JAW CLICKING/POPPING?
6. ___ ARM PAIN, HAND PAIN?
7. ___ NUMBNESS IN ARM, HAND OR FINGERS?
8. ___ CHEST OR RIB PAIN?
9. ___ MIDDLE BACK PAIN OR STIFFNESS?
10. ___ LOW BACK PAIN OR STIFFNESS?
11. ___ PAIN IN THE BUTTOCKS?
12. ___ LEG PAIN?
13. ___ NUMBNESS OR TINGLING IN THE LEG(S)?
14. ___ KNEE, ANKLE, FOOT PAIN?
15. ___ FATIGUE? __MILD __MODERATE __ EXTREME
16. ___ INSOMNIA DUE TO PAIN?
17. ___ DIZZINESS?
18. ___ VISUAL BLURRING?
19. ___ DEPRESSION, ANXIETY?
20. ___ NAUSEA OR VOMITING?
21. IS YOUR CONDITION AGGRAVATED BY

    ___ SITTING
    ___ STANDING
    ___ BENDING
    ___ TWISTING
    ___ DRIVING
    ___ RISING FROM A SEATED POSITION
    ___ PERFORMING MY NORMAL JOB DUTIES
    WHICH INCLUDE:____
    ____
    ___ LYING DOWN
    ___ STRESS
    ___ FATIGUE
    ___ WALKING
    ___ LIFTING
    ___ SNEEZING OR COUGHING

22. WERE YOU EXPERIENCING ANY OF THE ABOVE WITHIN THE LAST SIX MONTHS PRIOR TO THE ACCIDENT? __YES __NO. IF YES, WHICH SYMPTOMS?__________________
    ____

V. CHANGES IN LIFESTYLE DUE TO THIS INJURY:

1. HAVE YOU MISSED ANY WORK AS A RESULT OF THIS ACCIDENT? __YES __NO
   DATES MISSED: FROM________ TO________.

VI. PREVIOUS AUTOMOBILE ACCIDENTS:

1. HAVE YOU HAD ANY PREVIOUS AUTO ACCIDENTS? __YES __NO
   IF YES, HOW MANY?____ WHEN?______________________________

PLEASE PROVIDE ALL INFORMATION IN FULL

VII. INSURANCE INFORMATION

1. YOUR AUTOMOBILE INSURANCE
   - A. NAME OF COMPANY________________________________
   - B. ADDRESS________________________________
   - C. NAME OF INSURED________________________________
   - D. NAME OF ADJUSTER________________________________
   - E. PHONE #________________
   - F. POLICY #________________ CLAIM #________________

2. YOUR HEALTH INSURANCE
   - A. NAME OF COMPANY________________________________
   - B. ADDRESS________________________________
   - C. NAME OF INSURED________________________________
   - D. PHONE #________________ POLICY #________________

3. OTHER PARTY'S AUTOMOBILE INSURANCE
   - A. NAME OF COMPANY________________________________
   - B. ADDRESS________________________________
   - C. NAME OF INSURED________________________________
   - D. NAME OF ADJUSTER________________________________
   - E. PHONE #________________
   - F. POLICY #________________ CLAIM #________________

4. DO YOU HAVE AN ATTORNEY REPRESENTING YOU ON THIS CLAIM? ________
   - A. NAME OF ATTORNEY________________________________
   - B. ADDRESS________________________________
   - C. PHONE #________________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE: Patient:____

Employer:____

Claim/Group:____

SS# / ID #:____

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

Dr. David L. Martin
13801-F Roswell Ave..
Chino, CA 91710

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:

Martin Chiropractic / Kinetic Sports Medicine
13801-F Roswell Ave.
Chino, CA 91710

The professional or medical expense 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 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. In the absence of such payment, doctor is further assigned all Causes of Action and necessary rights to collect such benefits or payments. It is agreed that payment to the doctor, pursuant to this authorization by any company, shall discharge said company only to the extent of such payment. The undersigned authorizes the doctor to contact the employer and /or Company responsible for the payment of any benefits for the purpose of determining the existence and extent of insurance benefits, and authorizes the release of any and all information in the possession of the employer and/or necessary to determine the existence and/or extent of such benefits.

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

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

Dated at____________________this______day of____________________20___

________________________ ________________________

Signature of Policyholder Witness

Signature of Claimant,if other than Policyholder________________________

MARTIN CHIROPRACTIC AND KINETIC SPORTS MEDICINE

NOTICE OF DOCTOR'S LIEN

Patient:______________________________ Date of Accident:____________________

I do hereby authorize ______________________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, judgement 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, judgement 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 fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered 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, judgement 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 await payment but may declare the entire balance due and payable.

DATE:____________________ ______________________________

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, judgement, or verdict, as amy 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.

DATE:____________________ ______________________________

Attorney's Signature

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

DOCTOR:______________________________

David L. Martin D.C.

ADDRESS: 13801-F Roswell Ave. Chino, CA 91710

THANK YOU!

MARTIN CHIROPRACTIC AND KINETIC SPORTS MEDICINE

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DATE:__________________________ ____

Patient's Signature

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DATE:__________________________ ____

Attorney's Signature

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

DOCTOR:_____________________________________

David L. Martin D.C.

ADDRESS: 13801-F Roswell Ave. Chino, CA 91710

THANK YOU!

MARTIN CHIROPRACTIC AND KINETIC SPORTS MEDICINE

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DATE:________________________ ____

Attorney's Signature

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

DOCTOR:______________________________

David L. Martin D.C.

ADDRESS: 13801 F Roswell Ave. Chino, CA 91710

THANK YOU!

DAVID L. MARTIN, D.C.
QME • AME • IME
PALMER GRADUATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of the Notice of Privacy Practices

______________________________ Date ______________
Signature

____
Print Name

REFUSAL TO ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES

We attempted to obtain a written acknowledgement of Notice of Privacy Practices, but were unable to do so because:

_____ Individual refused to sign the acknowledgement.

_____ We were unable to communicate with the individual about the acknowledgement.

_____ An emergency prevented us from obtaining the acknowledgement at this time.

_____ Other ____

____

______________________________ Date ______________
Signature of Staff Member

____
Print Name

13801 F Roswell Ave. ■ Chino, California 91710 ■ (909) 591-2525 ■ FAX (909) 464-9797
EMERGENCY (909) 464-3505

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery*. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

____

____

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

X ____________	X ____________	X ________
Patient Name	**Signature**	**Date**
____________	____________	________
Witness Name	**Signature**	**Date**

DAVID L. MARTIN, D.C.
QME • AME • IME
PALMER GRADUATE

COMPREHENSIVE CARE:

PERSONAL INJURY
WORKERS' COMPENSATION
CAR ACCIDENTS
SPORTS INJURIES

SPECIALIZING IN:

LOW BACK PAIN
HEADACHES
SCIATICA
NECK PAIN
CARPEL TUNNEL
STIFFNESS
ALLERGIES
SINUS TROUBLE
MENSTRUAL PROBLEMS
SHOULDER & KNEE INJURIES

THERAPEUTIC APPROACH:

ORTHOPEDICS
CHIROPRACTIC MANIPULATION
PHYSICAL THERAPY
MASSAGE THERAPY
NERVE CONDUCTION STUDIES
X-RAYS

FOR YOUR CONVENIENCE:

EVENING APPOINTMENTS & SATURDAYS
EXTENDED HOURS
24 HOUR EMERGENCY
HOME VISITS
INSURANCE BILLING

3rd PARTY LIEN AND ATTORNEY ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services from MARTIN CHIROPRACTIC I have been advised that the doctor providing services to me is willing to wait for payment for these services as a courtesy, provided that there continues to be a reasonable chance that payment will be made either by insurance reimbursement or out of the settlement of a liability claim or law suit.

I understand that if it is determined:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the doctor's charges, OR

2. If a liability claim exists, and my current attorney or any new attorney I may retain at a later date refuses to agree to protest the interest of the doctor by signing a lien agreement, OR

3. If I do not engage the services of an attorney,

I agree to pay for all services rendered to me on a current basis and any remaining balance owing on my account will be paid in full as soon as my liability claim is settled or within three months of the date of my last treatment, whichever occurs first. If I settle my case with a Third Party, the check for my treatment made by the 3rd Party will have both my name and MARTIN CHIROPRACTIC printed as the recipients.

Patient's Name ____________________ Patient's Date of Injury ____________________

Patient's Signature ____________________ Date ____________________

Witness ____________________ Date ____________________

13801-F Roswell Ave. Chino, California 91710 (909) 591-2525 FAX (909) 464-9797

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