Dr. Rebecca Bomgaars, Doctor of Chiropractic

5855 Naples Plaza Suite 208, Long Beach, CA 90803

Phone: 562-774-4197 **Fax:** 562-438-1222 **Email:** drrebecca@440chiro.com

Today's Date:_______________
First Name:_________________________ **Last Name:**_________________________

PHONE# _________________________ **Work Phone:** ____________________________

Address:____

City/State/Zip ____

Email address: _________________@_________________
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/_____ **Gender: ( ) Male ( ) Female**

Emergency Contact:
1) Name:____________________________ Phone:_____________________
2) Name:____________________________ Phone:_____________________

Your Employer:_______________________________ Occupation: _________________

Preferred Language: ____________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

OF CHILDREN ____________ MARITAL STATUS S M D W

SPOUSES NAME ____

PERSON RESPONSIBLE FOR PAYMENT ____

HOW WERE YOU REFERRED TO OUR OFFICE? Ex: FRIEND'S NAME _______________________

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? ______________

IF YES, WHEN?_________________________

Are you currently taking any medications? ____

Medication Name Dosage and Frequency (i.e. 5mg once a day, etc.)(Please include regularly used over the counter medications) ____
*If more than 3 medications, please continue list on back of page
Do you have any medication allergies? ____
Medication Name Reaction Onset Date Additional Comments __________________________________
HAVE YOU EVER HAD ANY SURGERIES?____

DRUGS YOU NOW TAKE: ___ASPRIN ___PAIN KILLERS ___ TRANQUILIZERS ___INSULIN ___BIRTH CONTROL PILLS___ OTHER (PLEASE LIST)

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Do you drink alcohol? _____ If yes, how much, what kind, and how often? ________________________

IS THIS INJURY/ILLNESS WORK-RELATED? _________

HAVE YOU REPORTED IT TO YOUR EMPLOYER? _________

Employer's Address: ____

IS THIS INJURY/ILLNESS RELATED TO AN AUTOMOBILE ACCIDENT? _____

(IF YES, PLEASE GIVE FOLLOWING INFORMATION)

AUTO INSURANCE CO. _____________________ POLICY# _____________ CLAIM# ___________

PHONE#___________

ADDRESS ____ AGENT'S NAME ________________________

NAME OF ATTORNEY ______________________ ADDRESS ________________________________

PHONE#____________

DO YOU HAVE ANY TYPE OF HEALTH INSURANCE? ______________________________________

MEMBER #_____________________________ POLICY/GROUP# __________________________

INSURANCE COMPANY _____________________ ADDRESS ________________________________

CUSTOMER SERVICE PHONE # (for providers)____

INSURED'S NAME __________________________ RELATION _______________________________ SOCIAL SECURITY#_____________________________ DRIVER'S LICENSE#____________________________

ARE YOU COVERED UNDER ANY OTHER GROUP OR INDIVIDUAL HEALTH POLICY THROUGH YOURSELF OR SPOUSE? ______

INSURANCE COMPANY _____________________ ADDRESS ____

POLICY/GROUP# __________________________ INSURED SS# _____________________________

WHAT IS YOUR MAJOR COMPLAINT? ____

IS THIS CONDITION DUE TO AN A) AUTO ACCIDENT B) WORK INJURY C) OTHER ACCIDENT D) UNKNOWN CAUSE E) ILLNESS

ARE THE SYMPTOMS: A) IMPROVING B) GETTING WORSE C) ABOUT THE SAME D) INTERMITTENT (COME AND GO)

DATE SYMPTOMS APPEARED _____________________________

CIRCLE ANY ACTIVITIES WHICH AGGRAVATE YOUR CONDITON:

A) STANDING B) WALKING C) SITTING D) LYING E) BENDING F) LIFTING G) TWISTING H) COUGHING I) OTHER_____________

HAVE YOU HAD THESE SYMPTOMS BEFORE? ___________ IF SO, WHEN? ___________________

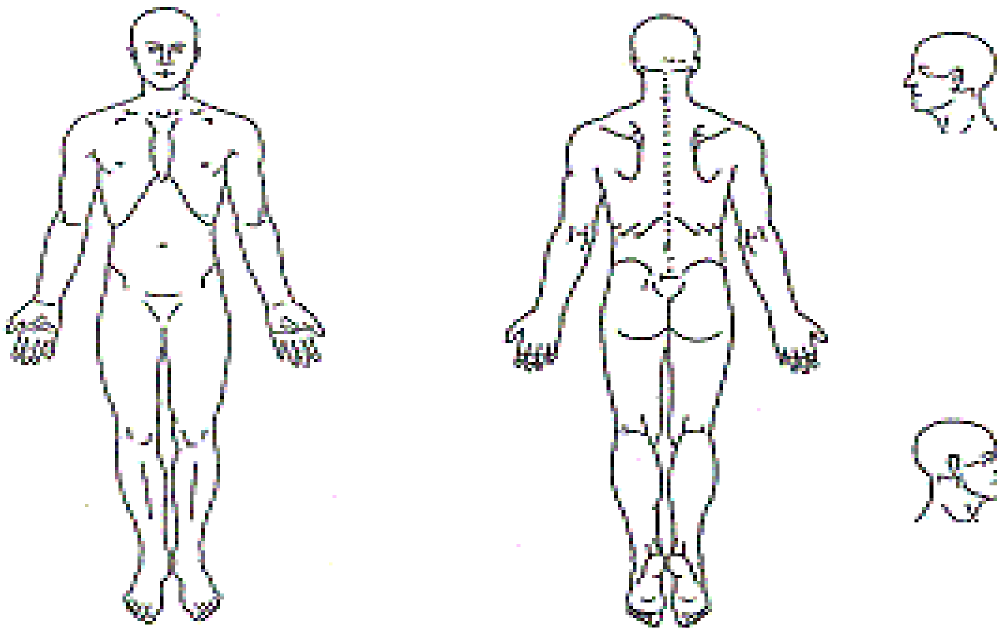
HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? A) M.D. B) CHIROPRACTOR C) OSTEOPATH D) ACUPUNCTURIST E) DENTIST F) PODIATRIST

DR.'S NAME ____ DATE CONSULTED _____________

DIAGNOSIS________________________

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW. 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, CONSTANT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

COMPLETE THESE DIAGRAMS



On a Scale of 0-10, what number would you give your pain? Please specify each area: ____________
____
____

Would you like a copy of your report every visit? _________________

PATIENT
SIGNATURE:_____________________________________Date:_____________

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Rebecca Bomgaars.

I have had an opportunity to discuss with Dr. Bomgaars and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

I, ________________________ authorize 4:40 Chiropractic to release any information pertinent to my case to business associates for purposes of carrying out billing and back office duties.

Patient's Name (Patient full Name) ___________________________________

Signature of Patient ____________________________Date: ______________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

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

Dr. Rebecca Bomgaars

4:40 Chiropractic

5855 Naples Plaza Suite 208,

Long Beach, CA 90803

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. We will do our best to verify your insurance coverage and will bill your insurance in a timely manner as a courtesy to you. Furthermore, I understand that 4:40 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 4:40 Chiropractic will be credited to my account on receipt. However, I 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 and treatment, any loss for professional services rendered me will be immediately due and payable.

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward charges for Professional Services rendered by 4:40 Chiropractic. I have agreed to pay the above-mentioned signee, in the current manner, and balance of said Professional Service charges over and above this Insurance payment.

A photocopy or facsimile copy of this Agreement shall be considered as effective and valid as the original.

I also authorize 4:40 Chiropractic to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case; and hereby release 4:40 Chiropractic of any consequences thereof.

Signature of Policy Holder _____________________Date________________

Signature of Claimant (If other than policy holder)

_______________________________________ Date________________