PATIENT INFORMATION

Name _____ Today's Date _____

Date of Birth _____ Height _____ Weight _____ Dominant Hand? R L

Address _____ City _____ Zip _____

Phone (cell) _____ Phone (other) _____

email _____ DL# _____

Health Insurance Company _____ Policy# _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Car Insurance Company _____

Address _____ City _____ Zip _____

Adjuster _____ Phone _____

Agent _____ Phone _____

Policy # _____ Claim # _____

What Medical Payments Coverage? _____ What Uninsured Motorist Coverage? _____

What Law Firm Represents You? _____

Address _____ City _____ Zip _____

Your Lawyer's Name? _____ Phone _____

Name of Insured on your Car Policy _____ For office use only Patient #

Date of Loss/Accident? _____ Date you first saw *any* Doctor after accident _____

Cost of all medical treatment since the accident? $ _____

How much income have you lost since the accident $ _____

What is the property damage (repair amount) of your car? $ _____

Name of your Personal M.D. _____ Phone _____

Address _____ City _____ Zip _____

Write any Ambulance, Hospital, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc., since accident

Name	Type	Phone#	Amount of Bill	For office use only Records Rec'd

Please use other side of page to write additional doctors & hospitals

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

IRREVOCABLE ASSIGNMENT OF BENEFITS

Patient Name: _____

Claim # _____ DOI: _____

SSN/ID # _____

Insured's Name _____ Relation to Insured _____

I hereby instruct and direct the _____ Insurance Company to pay the benefits of my policy by check made out to and mailed directly to

Dr. Dale T. Clark, D.C.
8907 Warner Avenue, Suite 160
Huntington Beach, Ca 92647
OR

If my policy prohibits direct payment to a doctor, then I hereby also instruct and direct you, my insurance company, to make the check out to me and mail it as follows:

C/O Dr. Dale T. Clark, D.C.
8907 Warner Avenue, Suite 160
Huntington Beach, CA 92647

For the professional or chiropractic/medical 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 AND IS IRREVOCABLE, EVEN BY MY ATTORNEY. DO NOT PAY THE BENEFITS OF THIS POLICY TO MY ATTORNEY AND DO NOT MAIL ANY BENEFIT CHECKS TO MY ATTORNEY. Said payment will not exceed my indebtedness to Dr. Clark and I have agreed to pay, in a current manner, any balance of said professional services fees over and above this insurance payment. If my policy is an indemnity policy, I hereby direct you, my insurance company, to indemnify me against the harm that would occur should Dr. Clark have to balance bill me for professional fees that I contracted for and that you, my insurance company, fail to pay or fail to pay in full.

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

I also authorize Dr. Clark to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I further authorize Dr. Clark to file a complaint on my behalf with the California Insurance Commissioner or the California Department of Managed Health Care.

Date: _____

Signature of Policyholder: _____

Signature of Claimant, if other than Policyholder: _____

NOTICE OF DOCTOR LIEN ON PERSONAL INJURY PROCEEDS

I hereby authorize **Dr. Dale Clark** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me in regard to the accident on or about _____, for which you have been retained.

I understand that all bills incurred by me at **Dr. Clark's** office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with **Dr. Clark**. I also understand that, unlike my attorney, **Dr. Clark** does not work on a contingency fee and I must pay for his services at the time of his rendering of them and that this lien is only to protect his interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed **Dr. Clark** for my health care in connection with this accident and pay it directly and promptly to **Dr. Clark** at:

Dr. Dale Clark, D.C.
8907 Warner Avenue, Suite 160
Huntington Beach, CA 92647

I am granting **Dr. Dale Clark** an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case. In the event I have no attorney, I hereby instruct any insurance company from which I may receive a settlement in regard to this accident to add Dr. Dale Clark, D.C. as a payee on the settlement draft.

_____ _____
Print Name Patient's Signature

Date of Signature _____ Date of Accident _____

I, the attorney of record for the above-named signatory in regard to the accident in question, hereby agree to abide by the terms of this lien.

_____ _____ _____
Print Name of Attorney Attorney's Signature Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____
Date of Birth _____ SS# _____
I authorize the release of Health Information to:

Dale T. Clark, D.C.
8907 Warner Avenue, Suite 160
Huntington Beach, CA 92647
(714) 842-6122 Fax (714) 375-2591

INFORMATION TO BE RELEASED

_____ Complete Medical Record Including Billing Statement and Reports
_____ Billing Statements
_____ Laboratory Reports
_____ Dental Records
_____ Pathology Reports/Records
_____ Diagnostic Imaging Reports
_____ Discharge Summary
_____ Emergency Medicine Reports/Records
_____ History & Physical Exam Reports/Records
_____ Operative Reports/Records
_____ Diagnostic Imaging Films

SPECIFIC AUTHORIZATIONS

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35)
_____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328, *et seq.*)
_____ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code § 120980(g))
_____ I specifically authorize the release of genetic testing information (Health and Safety Code § 124980(j))

THE PURPOST OF THIS RELEASE IS (check one or more)

_____ Continuity of care or discharge planning
_____ Billing and payment of bill
_____ At the request of the patient/patient's representative
_____ Review of records
_____ Other (state reason) _____

NOTICE

Health Care Providers and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: (1) conducting research-related treatment; (2) obtaining information in connection with eligibility or enrollment in a health; (3) for determining an entity's obligation to pay a claim; or (4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

I may revoke this authorization at any time, provided that I do so in writing and submit it to: DR. DALE T. CLARK, D.C.. This revocation will take effect when received by DR, DALE T. CLARK, D.C., except to the extent that DR. DALE T. CLARK, D.C. OR OTHER HAVE ALREADY RELIED ON IT.

I am entitled to received a copy of this Authorization

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____ *(insert applicable date or event). If not date is indicated, this authorization will expire 12 months after the date of signing this form.*

SIGNATURE

_____ _____

(Signature of Patient or Patient's Legal Representative) Date

_____ _____ AM PM

Printed Name Time

_____

(Legal Relationship of Signatory if not Patient)

_____

Signature of Witness or Translator