Today's Date _____

Full Name _____

Address _____City _____

State _____ Zip _____

E-mail _____

Home Phone # _____ Cell # _____ Work Phone # _____

Age _____ Birth Date _____ Gender _____ SS# _____

How did you hear about Dr. Dave, or who can we thank for your being here?

_____

Are you concerned about (circle all that apply): your neck, back, low back, other

_____

Is your visit today due to a car accident? _____ If yes, please fill out the back of this form.

Please confirm your information is correct and provide your signature below:

Signature _____ Date _____

PERSONAL INJURY QUESTIONNAIRE

Date of Accident/Injury:_____/_____/_____Date you first saw any doctor after the accident:____/_____/_____
Time of accident: _____:_____ am pm City accident occurred in:_____
Intersection/Cross Streets accident occurred on:_____
How many vehicles were involved?_____
Your vehicle information: Make:_____ Model:_____Year:_____
Other vehicle information: Make:_____ Model:_____Year:_____
Approximate speed of your vehicle_____MPH Other Vehicle _____MPH
Point of impact on the vehicle? _____Front _____Rear _____Left Side _____Right Side
Indicate if you were: Driver _____ Front Passenger _____ Rear Passenger_____
How much income have you lost since the accident? $_____Amount of days missed at work:_____
What is the amount of property damage (repair amount) of your vehicle? $_____
Would you assess the damage to your vehicle as: _____Mild _____Moderate _____Severe _____Totaled
Were police notified? ____Yes ____No Were you taken to the hospital by ambulance?____Yes____No
Have you ever been involved in a previous motor vehicle accident? _____Yes _____No
Number of people in the vehicle_____Were you wearing a seatbelt at the time of impact? _____Yes_____No
Were you knocked unconscious? _____Yes_____No

In your own words, please describe the accident:
_____
_____
_____

Please describe how you felt :

During the accident_____

Immediately after the accident:_____

Did the accident force you to take any medications?_____ If so, what? _____

AUTO INSURANCE / ATTORNEY INFORMATION

Did the car that hit you have insurance?_____

Do you have an attorney?_____

Do you have medical payment coverage on your auto policy (known as med pay)? ___Yes___No Amount $_____
Your Auto Insurance Company:_____Phone_____
Policy #_____Claim#_____Adjuster Name:_____
Attorney Name:_____

Phone # (_____)_____

_____ _____

Patient Signature Date

Acosta Chiropractic and Wellness Center 11498 Pierce St. Suite A1 Riverside, CA 92505 951-354-6294

PATIENT CONSENT FORM FOR CHIROPRACTIC 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 who I am legally responsible) by Dr. Rey David Acosta, D.C.

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based on the facts the known, and is in my best interest.

Our office uses sign in sheets and provides care in an "open door" adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be an earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/address/ e-mail you list on this intake form. If you do not wish to be contacted at any listed numbers/address/ e-mail, please let us know.

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intent this consent form to cover the entire course of treatment for my present condition (and for any future conditions) for which I seek treatment at this office.

Patient's Name (please print)_____ Date_____

Signature of patient (or guardian if patient is a minor)

_____

Doctor's Signature_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected information I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a copy of the current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my information is used for disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to agree by such restrictions.

Patient's First Name	Middle Initial	Last Name

Insured Name _____

Address _____

Number	Street	Unit #

_____

City	State	Zip

Signature _____

Date _____