DAVID L. MARTIN D.C.
KYLE R. CARPENTER B.S., D.C.

MARTIN CHIROPRACTIC

KINETIC SPORTS MEDICINE

INSURANCE PACKET

PATIENT INFORMATION: TODAY'S DATE: _____

FULL NAME: _____ SS#: _____

HOME ADDRESS: _____ (UNIT/SUITE/APT#): _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

CELL PHONE#: _____ SEX: M_____ F_____

DATE OF BIRTH: _____ AGE:_____ HEIGHT: _____ WEIGHT: _____

PRIMARY PHYSICIAN (NAME, ADDRESS, PHONE NUMBER):

_____

_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY INSURANCE CARRIER:

COMPANY:_____ NAME OF INSURED: _____

BILLING ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

PHONE: _____ MEMBER ID #:_____

SECONDARY INSURANCE CARRIER (if applicable):

COMPANY:_____ NAME OF INSURED: _____

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ MEMBER ID #:_____

PATIENT EMPLOYMENT INFORMATION

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____

SPOUSE/EMERGENCY CONTACT

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

SPOUSE'S NAME: _____

SPOUSE'S DOB: _____ SPOUSE'S PHONE#:_____

EMERGENCY CONTACT (NAME & PHONE NUMBER):

_____

STATEMENT:

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)

PATIENT FAMILY MEDICAL HISTORY:

Please check off if anyone in your family has had problems with:

___Diabetes, Thyroid, or other
___Endocrine Disorders
___Hypertension
___Lipid Disorders
___Cardiovascular Disease
___Prostate Disease
___Cancer
___Other Illness not noted

PATIENT MEDICAL HISTORY:

Please check off if you have a history or early finding of the following:

___Pregnant/Lactating
___Blood Disorders
___Cancer
___Immune Disorders
___Poor wound healing
___Edema/excess fluid retention
___High Cholesterol
___Upper respiratory problems
___Lung Disorder
___High Blood Pressure
___Renal Disease
___Heart Attack
___Emotional Disorders
___Genital-Urinary Disorder
___Glaucoma
___Carpal Tunnel Syndrome
___Surgery
___Drug Allergies
___Chemical Dependency
___Food Allergies

If you checked off any item above, please explain: _____
_____
Do you get regular exercise? _____ If yes, what type frequency, duration, & where?_____
Please list any medications used in the past 12 months?_____
_____

DAVID L. MARTIN D.C.
KYLE R. CARPENTER B.S., D.C.

CONFIDENTIAL HEALTH QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

CHECK CONDITIONS THAT APPLY:

GENERAL

___ALLERGY
___FATIGUE
___CONSTIPATION
___DIARRHEA
___NAUSEA
___VOMITTING
___DIZZINESS
___PAINFUL BREATHING
___ASTHMA
___HIGH/LOW BLOOD PRESSURE
___FREQUENT URINATION
___PAINFUL URINATION
___PROSTATE TROUBLE

MUSCLE/JOINTS

___HEADACHES
___NECKPAIN/STIFFNESS
___SHOULDER PAIN
___ARM PAIN, NUMB
___ELBOW PAIN
___WRIST/HAND PAIN
___MID BACK PAIN
___LOW BACK PAIN
___HIP PAIN
___SCIATICA
___KNEE PAIN
___LEG PAIN/NUMBNESS
___FOOT/ANKLE PAIN/NUMBNESS

REASON FOR VISIT: _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

GETTING WORSE OR BETTER? _____ INITIAL CAUSE OF PAIN? _____

DO YOU HAVE PAIN DURING ___AM ___PM ___WORK ___HOME

___SLEEP ___RISING ___ACTIVITY

DAVID L. MARTIN D.C.
KYLE R. CARPENTER B.S., D.C.

ACKNOWLEDGEMENT OF "NOTICE OF PRIVACY PRACTICE"

PRINT NAME: _____ DATE: _____

PATIENT'S SIGNATURE: _____
(If patient is a minor, parent or guardian's signature is required)

- The HIPPA Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. If you would like a copy of this notice, please let us know.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT OF YOUR PAIN

The nature of Chiropractic Treatment: The doctor will use his/her 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 he/she 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 other medical conditions you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*
Other options for 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: _____

My signature below confirms that I have read the paragraphs above and that I understand the 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.

PATIENT SIGNATURE: _____ DATE: _____

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. Patient's Name (Last Name, First Name, Middle Initial)

2. Patient's Date of Birth

3. Insured's Name (Last Name, First Name, Middle Initial)

4. Patient's Address (Street, City, State, Zip Code)

5. Patient's Sex
Male ☐ Female ☐

6. Insured's I.D. No. (For program checked above, include all letters)

7. Patient's Relationship to Insured
Self ☐ Spouse ☐ Child ☐ Other ☐

8. Insured's Group No. (or group name or FECA claim no.)
☐ Insured is employed and covered by employer health plan

9. Other Health Insurance Coverage (Enter Name or Policyholder and Plan Name and Address and Policy or Medical Assistance Number)

10. Was Condition Related To:
A. Patient's Employment
Yes ☐ No ☐
B. Accident
Auto ☐ Other ☐

11. Insured's Address (Street, City, State, Zip Code)
Telephone No.

11a. CHAMPUS SPONSOR'S
Status ☐ Active Duty ☐ Deceased ☐ Retired
Branch of Service

12. Patient's or Authorized Person's Signature
I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
X Signed Date

13. I authorize payment of medical benefits to undersigned physician or supplier for service described below.
X Signed (Insured or authorized person)

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of Illness (First symptom) or Injury (Accident) or Pregnancy (LMP)

15. Date You Were First Consulted For This Condition

16. If Patient Has Had Same or Similar Illness or Injury, Give Dates

16a. If Emergency Check Here ☐

17. Date Patient Able To Return To Work

18. Dates of Total Disability From Through

Dates of Partial Disability From Through

19. Name of Referring Physician or Other Source (e.g., Public Health Agency)

20. For Services Related To Hospitalization Give Hospitalization Dates
Admitted Discharged

21. Name & Address of Facility Where Services Rendered (If other than home or office)

22. Was laboratory work performed outside your office?
Yes ☐ No ☐ Charges

23. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference numbers 1, 2, 3, etc. or DX code.
1.
2.
3.
4.

24. A Date of Service From To	B* Place of Service	C Fully describe procedures, medical services or supplies furnished for each date given: Procedure Code (Identify) / (Explain unusual services or circumstances)	D Diagnosis Code	E Charges	F Days or Units	G* T.O.S.	H Leave Blank

25. Signature of physician or supplier (Including degree(s) or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof)

26. Accept assignment (Government claims only)
Yes ☐ No ☐

27. Total Charge

28. Amount Paid

29. Balance Due

30. Your social security no.

31. Physician's suppliers and/or group name, address, zip code and telephone no.

32. Your patient's account no.

33. Your employer I.D. no.

I.D. NO.

*Place of service and type of service (T.O.S.) codes

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE

Reorder H.J. Ross Co. (714) 539-2130
A104

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

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

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___

X_____ _____

Signature of Policyholder Witness

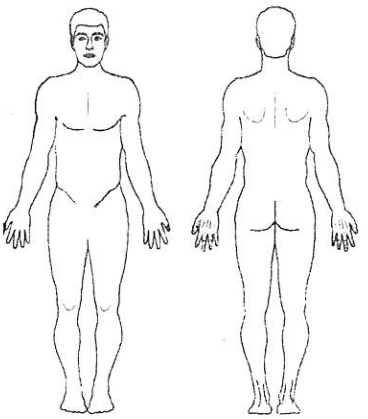
Signature of Claimant,if other than Policyholder_____

American Specialty Health Plans (ASHP)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____
_____
_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications: _____
☐	☐	Cancer/Tumor			_____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma			

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

X **Patient Signature:** _____ **Date:** _____