Dirk Weddle, D.C.

Initial Health Status
Name:
Date:

Patient Name: _____ Birthdate: _____ Sex: ☐

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #- _____ Driver Lic. #- _____

Occupation: _____ Employer: _____ Work Phone: _____

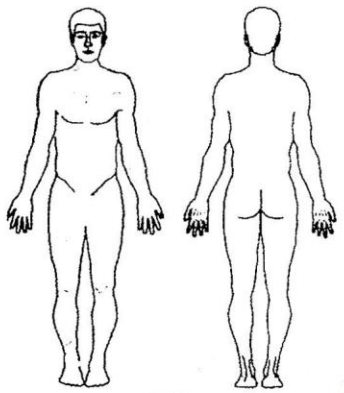
Address: _____ City: _____ State: _____ Zip: _____

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
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Surgeries/Medications: _____

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.

Patient Signature: _____ Date: _____

Dirk Weddle, D.C.

Patient Information for Medical Records
Name:
Date:

Patient _____ _____ [ ]
Last Name First Name M.I.

Birthdate _____ Marital Status- S M D Sep W Referred by _____

Driver's License #- _____ Social Security #- _____

E-Mail _____ Cell Phone _____

Home Address _____ Home Phone _____

City _____ Zip _____ Occupation _____

Employer _____ Work Phone _____

Address _____ City _____ Zip_____

Parent (if minor) / Spouse _____ Relation _____

Social Security # _____ Birthdate _____

Employed by _____ Work Phone _____

Address _____ City _____ Zip_____

Emergency Contact (Name)_____ Relation _____

Address _____City _____ Phone

CONSENT FOR TREATMENT

1, the undersigned, hereby authorize Dr. Dirk Weddle, D.C. and whomever he/she may designate as his/her assistant(s) to perform diagnostics tests, including but not limited to radiographs and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's signature_____Date_____

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize _____D.C. and whomever he/she may designate as his/her assistant(s). To perform diagnostic tests, including but not limited to radiographs and to administer treatment as he/she deems necessary to my son/daughter, (name) _____

Patient's signature_____Date_____

Dirk Weddle, D.C.

Insurance Information and Verification

Name:

Date:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information to this clinic is correct and complete. Further, I understand I am to notify this office immediately if this information changes in any way, is terminated or results in COBRA benefits.

Patient's signature _____ Date_____

AUTHORIZATION FOR PATIENT CONTACT

I authorize the doctor and the doctor's office staff to contact me at my work and/or at my home and/or at my cell contact numbers. Further, I understand I am to notify this office if my contact information changes.
I would prefer to be called at ☐Home ☐Work ☐Cell

Patient's signature _____ Date_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the doctor and/or the doctor's staff has provided me with a paper copy of Notice of Privacy Practices, or an electronic copy of the Notice of Privacy Practices, or has offered the opportunity to read the Notice of Privacy Practices. I understand I may request a copy of the Notice at any time.

Patient's signature _____ Date_____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize _____ to pay by check the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay in a current manner any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's signature _____ Date _____

INSURANCE INFORMATION - Card Provided Yes / No The following to be filled out if there is no card available:

Primary Insurance:

Insured Name _____ Soc. Sec # _____ DOB_____

Patient Name _____ Self___ Spouse___ Child___ DOB_____

Employer _____ Phone _____

Insurance Co. _____ Policy #_____ Group# _____

Billing Address: _____ Phone _____

For Staff Use Only

INSURANCE VERIFICATION - OUTPATIENT BENEFITS

Deductible $ _____ per year or annual? $ _____ has been met. Co-Pay $ _____ % _____

Maximum # of visits _____ Report for more? Yes/ No Maximum $ per visit _____ per year _____

Authorization required ? Yes / No From _____ Phone _____

Is physical therapy covered? Yes / No Are X-rays covered? Yes / No Are there any restrictions? _____

Name of verifier at Ins. Co._____ Name of staff _____Date_____

To:

From:Dirk Weddle, D.C.
15375 Barranca Pkwy, Ste J 104
Irvine, CA 92618
Phone: (949)387-6851

ASSIGNMENT AND LIEN AUTHORIZATION

I do hereby authorize Dirk Weddle, D.C. and/or his authorized representatives to furnish my attorney _____ said named attorney or substitute in his place, with a full report of my examinations, diagnoses, treatments, prognosis, itemized statements of charges incurred, etc. of myself in regard to the injuries suffered by me in an accident in which I was involved on _____ and hold Dirk Weddle, D.C. free and harmless from any liability in such transfer of information.

Out of the proceeds of the settlement and/or judgment in my claim for personal injuries, I hereby assign, set over and transfer to Dirk Weddle, D.C. such sums due and owing to his for medical, x-ray, and/or laboratory services rendered me by reason of the above accident. I further give to Dirk Weddle, D.C. a lien on any and all funds received by me or in my behalf in connection with the settlement or satisfaction of judgment arising from said claim presented in my behalf.

I fully understand that I am directly responsible to said Dirk Weddle, D.C. for all medical bills submitted by him for services rendered me, and I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. Should I dismiss you, my doctor, for any reason I understand that the billings may become immediately due and payable. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered.

It is acknowledged by the undersigned that this assignment and lien is further consideration for the services rendered to me by Dirk Weddle, D.C. in addition to the obligation to pay for medical services.

A PHOTOGRAPHIC/FAX REPRODUCTION OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL

DATED: _____

PATIENT'S SIGNITURE: _____
PRINTED NAME: _____
PARENT/GUARDIAN SIGNITURE: _____

AGKNOWLEDGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY

The undersigned, being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby acknowledge receipt of a copy of the assignment and lien, and said attorney acknowledges that he obligates himself to the terms of the assignment and lien in consideration for the rendering of medical services to his client by Dirk Weddle, D.C. and rendering of a report and bill to said attorney. I understand that if for any reason the above named client dismisses my services, I will inform said doctor of such dismissal. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered.

ATTORNEY: _____
BY: _____
DATED: _____

NO CHANGES OR ALTERATIONS OF THE SUMS BILLED HEREIN WILL BE ACCPTED UNLESS CONFIRMED IN WRITING BY THE DOCTOR

O.C. Chiropractic & Wellness Center

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The Chiropractor is required by law to provide each patient with a Notice of Privacy Practices, which describes how their health information may be used and disclosed as well as their rights regarding their health information. The undersigned hereby acknowledges that they have received a copy of the Notice of Privacy Practice.

_____ _____

Signature of Patient/Guardian Date

DISCLAIMER: CONTENTS ARE INFORMATIONAL AND ARE NOT INTENTED AS LEGAL ADVICE. THERE IS NO REPRESENTATION, GUARANTEE OR WARRANTY, EXPRESSED OR IMPLIED, THAT THESE FORMS ARE ERROR FREE, OR THAT THE USE OF THIS INFORMATION WILL PREVENT DIFFERENCES OF OPINION OR DISPUTES WITH ANY OTHER PARTY, AND WILL BEAR NO RESPONSIBILITY OR LIABILITY FOR THE RESULTS OR CONSEQUENCES.

I, _____, may be contacted for any messages and/or lab/test
Patients Name
results at:

HOME _____ Okay to leave message ☐ Yes / No ☐

WORK _____ Okay to leave message ☐ Yes / No ☐

CELL _____ Okay to leave message ☐ Yes / No ☐

O.C. Chiropractic & Wellness Center

I am fully aware that if my _____ health insurance does not cover my
Insurance Name

Office visit on _____ with Dr. Weddle, D.C., O.C. Chiropractic I will
Date

Be responsible for the total bill.

PLEASE PRINT

Insurance Name:_____

Insurance ID # _____

Co-Payment &/or Deductable: _____

Primary Insurance Holder: _____

Subscriber's SS#:_____

_____ _____
Signature Date

Informed Consent Form

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome [(2)] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have every felt[(3)]

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery[5].
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

PLEASE DO NOT SIGN THIS FORM UNTIL AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	
Have you ever been diagnosed with cancer?	☐	
Do you have any metal implants?	☐	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	☐	
If yes, about how much do you take daily? _____		
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	☐	
Have you ever been diagnosed with any of the following disorders/diseases?		
• Rheumatoid arthritis	☐	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	☐	
• Giant cell arteritis (temporal arteritis)	☐	
• Osteogenesis imperfecta	☐	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	☐	
• Medial cystic necrosis (cystic mucoid degeneration)	☐	
• Bechet's disease	☐	
• Fibromuscular dysplasia	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	☐	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	☐	
Have you been diagnosed with spondyliolithesis?	☐	
Have you had any of the following problems?		
• Sudden weakness in the arms or legs?	☐	
• Numbness in the genital area?	☐	
• Recent inability to urinate or lack of control when urinating?	☐	

I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT [or PARENT/GUARDIAN] SIGNATURE _____ DATE _____

INTERN SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____