The Office of Dr. Nathaniel Elkins

11500 West Olympic Blvd, Suite 364, Los Angeles, CA 90064

Date: _____

Name_____Address _____
City _____ State _____ Zip _____Home Phone _____
Cell Phone_____ _____ Email: _____
SS# _____Date of Birth _____Age _____ Height _____ Weight _____

Male Female Single Married Divorced # of Children _____ Name of Spouse (or parent) _____

How were you referred to our office? _____Drivers License # _____

Employer _____Address_____
City _____State ____ Zip _____Wk Phone _____Occupation _____

Have you ever had Chiropractic care before? _____ If Yes, When? _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)
1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

List other doctors consulted for these conditions: 1. _____ 2. _____
Name of family physician _____

Do you ever experience any of these complaints while working? _____ If yes, please describe what activities at work that may be causing them: _____
_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____
If yes, please explain: _____
_____

If this is due to an injury or accident, what is the date of injury? _____
Has this problem been getting better, worse, or staying the same? _____
What activities make your condition worse? _____
_____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____
_____

Please list any injuries or illnesses that you have had that are not listed above:
_____

Please list any over-the –counter or prescription medications you are currently taking: Aspirin/Tylenol Pain Killers Muscle Relaxers Insulin Tranquilizers Birth Control Pills Others_____

Have you been involved in an auto accident in the last 12 months? _____ If yes, when? _____

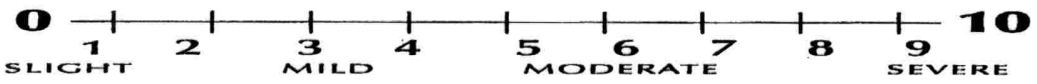
Health Insurance _____ Policy Holder _____
Claims Address _____ Policy Number _____
Spouse's Health Insurance _____ Policy Holder _____
Claims Address Policy Number

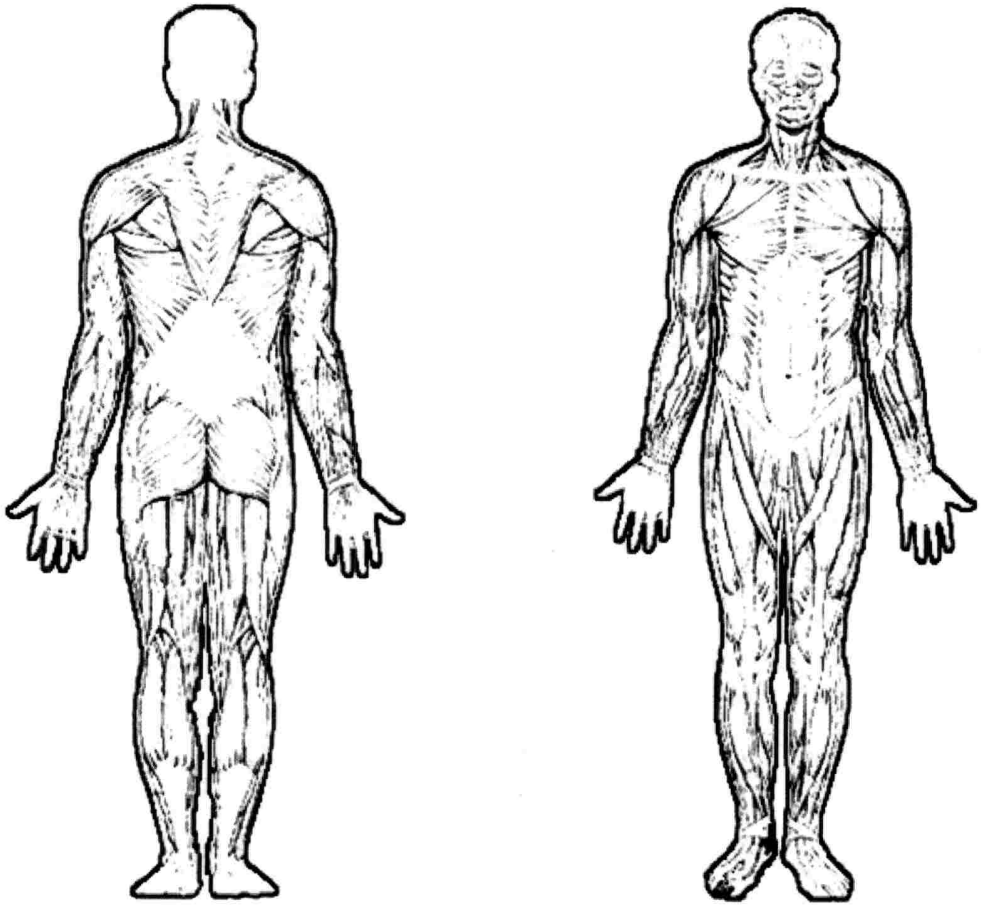
If you are experiencing any health problems, please mark the exact location of you pain on the diagram below. Also describe the type and frequency of your pain.

For Example: dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS

PLEASE CIRCLE YOUR LEVEL OF PAIN





Method of payment for today's charges: Î Cash Î Check Î Credit Card Î_____

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I HEREBY GIVE LIFETIME AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO Dr. Nathaniel Elkins AND TREATING DOCTORS, FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE IN THE EVENT OF DEFAULT. I AGREE TO PAY ALL COSTS OF COLLECTION AND REASONABLE ATTORNEY'S FEES FOR COLLECTION OF FEES. I HEREBY AUTHORIZE Dr. Nathaniel Elkins TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF INSURANCE BENEFITS. I FURTHER AGREE THAT A PHOTOCOY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

Patient's Signature_____ Date_____

IMPORTANT: *Please check ✓ all present symptoms*

▶ HEAD

_____ sinus (allergy)
_____ entire head
_____ back of head
_____ forehead
_____ temples
_____ migraine

_____ head feels heavy
_____ loss of memory
_____ light-headedness
_____ fainting
_____ light bothers eyes
_____ blurred vision
_____ double vision

_____ loss of vision
_____ dizziness
_____ loss of hearing
_____ pain in ears
_____ ringing in ears
_____ buzzing in ears

▶ NECK

_____ pain in neck
_____ neck pain with movement
_____ forward
_____ backward
_____ turn to left
_____ turn to right
_____ bend to left
_____ bend to right
_____ pinched nerve in neck
_____ neck feels out of place
_____ muscle spasms in neck
_____ grinding sounds in neck
_____ popping sounds in neck
_____ arthritis in neck

▶ ARMS & HANDS

_____ pain in upper arm
_____ pain in elbow
_____ movement aggravated
_____ tennis elbow
_____ pain in forearm
_____ pain in fingers
_____ sensation of pins and needles in arms
_____ sensation of pins and needles in fingers
_____ numbness in arms (R / L)
_____ fingers go to sleep
_____ hands cold
_____ swollen joints in fingers

▶ SHOULDERS

_____ pain in shoulder joint (R / L)
_____ pain across shoulder
_____ bursitis (R / L)
_____ arthritis (R / L)
_____ can't raise arm:
  _____ above shoulder
  _____ over head
_____ tension in shoulders
_____ pinched nerve in shoulder (R/L)
_____ muscle spasms in shoulders

▶ MID BACK

_____ mid-back pain location:
_____
_____
_____ pain between shoulder blades
_____ sharp stabbing
_____ dull ache
_____ pain from front to back

_____ muscle spasms
_____ pain in kidney area
_____ irregular heartbeat

▶ CHEST

_____ chest pain
_____ shortness of breath
_____ pain around ribs
_____ irregular heartbeat

▶ ABDOMEN

_____ nervous stomach
_____ foods can't eat: _____
_____
_____ nausea
_____ gas
_____ constipation
_____ diarrhea

▶ LOW BACK

_____ low-back pain
_____ upper lumbar
_____ lower lumbar
_____ sacroiliac
_____ low back pain worse when:
  _____ working
  _____ lifting
  _____ stooping
  _____ standing
  _____ sitting
  _____ bending

▶ HIPS, LEGS & FEET

_____ pain in buttocks
_____ pain in hip joint
_____ pain down leg
_____ knee pain
  ____ inside
  ____ outside

_____ leg cramps
_____ cramps in feet
_____ pins & needles in legs
_____ numbness of leg
_____ numbness in toes
_____ feet feel cold
_____ swollen ankles or feet

▶ WOMEN ONLY

_____ menstrual pain
_____ cramping
_____ irregularity
_____ cycle: _____ days
_____ are you, or do you think you are pregnant?

▶ MEN ONLY

_____ urinary frequency: _____
_____ difficulty in starting
_____ night urination
_____ prostate pain/swelling?

▶ GENERAL

_____ nervousness
_____ irritable
_____ depressed
_____ fatigue
_____ generally feel run-down
_____ normal sleep _____
_____ loss of sleep _____
_____ loss of weight _____ lbs.
_____ coffee _____ cups/day
_____ tea _____ cups/day
_____ cigarettes _____ packs/day
_____ other
_____ diabetes
_____ hypoglycemia

▶ REMARKS

_____
_____
_____
_____
_____
_____

Privacy Form

Patient's Name: _____
Patient's SS # :_____ Date of Birth: _____

PHI (Protected Health Information)

PHI is defined as any personal information which you provide to this office and includes any medical information you provide or information the doctor ascertains during your examination or treatment. This office protect your PHI and it will be kept completely confidential.

Specific Authorizations

- I give permission to the Dr. Nathaniel Elkins and Staff to contact me to relay health related and other information.

- I give the Dr. Nathaniel Elkins and Staff permission to treat me in a room where other patients are being treated. I am aware that other persons in the office, during my course of care, may overhear interactions with the doctor and staff. Should I require private contact with the doctor or staff at any time, a private room for these conversations or treatment will be provided. .

Expiration

The Authorization shall not expire unless revoked by the patient as described below.

Right To Revoke Authorization

- You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke the authorization is not effective to the extent that we have provided services or taken action in reliance on your previous authorization.

- You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Dr. Nathaniel Elkins and Staff. The written notice must contain the following information:
  -Your name, Social Security number and date of birth, a clear statement of your intent to revoke this authorization, the date of your request and your signature.

- The revocation is not effective until the privacy official receives it.

- This authorization is requested by the Dr. Nathaniel Elkins and Staff for its own use/disclosure of PHI. (minimum necessary standards apply)

- You have the right to refuse this authorization. If you refuse to sign this authorization Dr. Nathaniel Elkins and Staff will not refuse to provide you treatment. You have the right to inspect or copy your PHI . Upon request, a copy of this authorization will be provided to you.

Patient Signature: _____ Date: ____

PATIENT'S FINANCIAL RESPONSIBILITY

In order to prevent any misunderstanding regarding the office's billing and insurance policy, we would like our patients to aware of the following:

1.) As a COURTESY the office of Dr. Nathaniel Elkins will bill the insurance company and wait for payment, for his current treating patients. We do everything possible to get accurate insurance information, inform the patient of their benefits, and collect from the insurance company in a timely manner. However, should there be a problem with the insurance company payment, or if the insurance company has not paid within 60 days, the bill will be due and payable and the patient will be billed directly.

2.) You are responsible for deductibles and co-payments (the portion the insurance company does not cover) at the time of visit.

3.) You are responsible for all supplements and supplies at the time of your visit. Insurance companies usually do not pay for supplements or supplies. If the supplements and supplies are paid for by the insurance company, the patient will either be reimbursed by the office or payment will be credited to the patient's account.

4.) For your convenience, our office accepts most major credit cards. We are always happy to receive cash payments. We realize that it may be inconvenient to make a payment at each office visit. Therefore, our policy is that all fees be paid on a weekly basis, or by written agreement with a staff member.

5.) It is our office policy not to carry co-payments or any other balances over one hundred fifty dollars ($150) other than expected insurance reimbursements.

6.) If you discontinue care and treatment for any reason other than being discharged by the doctor, all fees for services will be due and payable immediately. _____ INITIAL

7.) I Understand that I am ultimately responsible for all fees for services rendered. _____ INITIAL

Your cooperation is truly appreciated. If you have any questions, please feel free to discuss them with our staff. We thank you for staying current with your payments at our office.

I HAVE READ AND AGREE TO THE ABOVE POLICY.

PATIENT'S SIGNATURE: _____ DATE: _____

PRINT PATIENT'S NAME: _____

THE OFFICE OF DR. NATHANIEL ELKINS, DC

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including diagnostic x-rays on me, by the doctor of chiropractic named below and/ or anyone working in this clinic authorized by the doctor of chiropractic listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of the chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscles strains and sprains, disc injuries, and strokes. Since I do not expect the doctor to anticipate and explain all risks and complications, 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 interests.

I have read the above consent. I have also had an 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 in this facility.

TO BE COMPLETED BY PATIENT:

_____

PRINT PATIENT 'S NAME

_____

SIGNATURE OF PATIENT {OR PARENT/ GUARDIAN) DATE SIGNED