BRENNER
CHIROPRACTIC

New Patient Information
No Fault

Patient's Name: _____ Initial Visit Date _____

Address _____ City _____ Zip_____

Date of Birth _____ SS# _____ Marital Status M S W D Sex M F

Telephone _____ Cell _____ Email Address _____

How did you hear about our office? _____

Insurance Information

Insured's Name: _____ Patient relation to insured:_____

Insurance Co Name: _____ Phone _____

Address _____ City _____ State_____ Zip _____

Date of accident _____ Policy # _____ Claim # _____

Adjuster's Name: _____ Phone _____

Attorney Information

Firm Name _____

Attorney Name _____

Address _____ City _____ State _____ Zip_____

Telephone # _____ Fax # _____

Verified By _____ Date _____

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Medical History Form

Name: _____ DOB: _____ Date:_____

Place an 'X' in the box to indicate if you have or have had any of the following:

□ Anemia
□ Arthritis
□ Asthma
□ Cancer
Specify: _____
□ Concussion
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fractures
□ Goiter
□ Headache
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herniated Disc
□ HIV / AIDS
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Migraines
□ Multiple Sclerosis
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Polio
□ Prostate Problems
□ Psychiatric Care
Specify:_____
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcers
□ Venereal Disease
Other:
_____

MEDICATIONS

_____
_____
_____

ALLERGIES

_____
_____
_____

VITAMINS/HOLISTIC THERAPY

_____
_____
_____

Are you pregnant? □Yes □No If Yes, due date: _____

Injuries / Surgeries you have had: Description Date

Falls: _____ _____
Broken Bones: _____ _____
Dislocations: _____ _____
Surgeries: _____ _____

EXERCISE

□None
□Moderate
□Daily
□Heavy

WORK ACTIVITY

□Sitting
□Standing
□Light Labor
□Heavy Labor

HABITS

□Smoking Packs/Day _____
□Alcohol Drinks/Wk _____
□Coffee / Caffeine Cups/Day _____
□High Stress Levels Reason _____

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Current Condition

Please complete ALL parts to this questionnaire.
This confidential history will be part of your permanent record. Thank you.

Name: _____ DOB: _____ Date:_____

Present Condition:

Reason for THIS visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Y N

Any other healthcare providers treating you for this? _____

If yes, whom:_____

What treatment(s) have you already received for your condition?

□ Physical Therapy □ Chiropractor □ Medication □ Surgery □ Injection(s)

□ Other _____

What tests have been done to you for this condition? If yes, please include date and results.

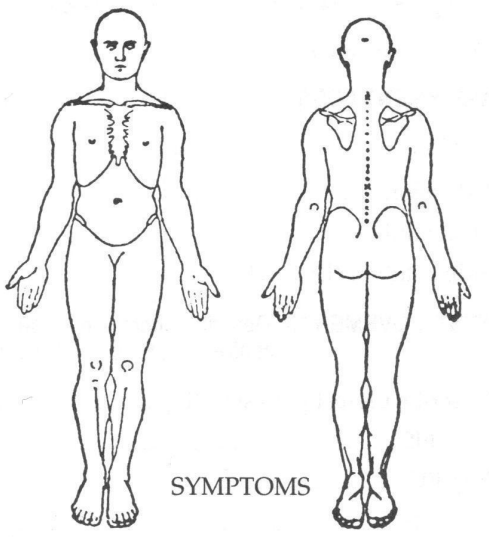
MRI: _____ X-Ray: _____

EMG / NCV: _____ Other: _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain): _____

Type of symptoms: □ Sharp □ Shooting □ Burning □ Dull □ Throbbing □ Aching
□ Cramping □ Stiffness □ Swelling □ Numbness □ Tingling
□ Other: _____

Please mark your symptoms on the picture on the right:
"X" = Pain / Tightness / Stiffness **"O"** = Numbness / Tingling



How often do you have this pain? (Please mark all that apply)

□ Constant □ Come and go □ Daily
□ Weekly □ Mornings □ End of day

Does it interfere with your:

□ Work □ Sleep □ Daily Routine □ Recreation

Activities that are painful to perform:

□ Sitting □ Standing □ Walking □ Bending □ Lying down

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Patient Questionnaire – Auto-Accident

Patient Name: _____DOB: _____Today's Date: _____

Date of Exam: ____/____/___ Provider: _____ New Patient □ Yes □ No

Basic Information about the Accident:

Date Accident Occurred or Started: ____/____/____
Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place: _____
_____
_____
_____

Describe the condition or symptoms caused by the Accident: _____
_____
_____
_____

Auto-Accident Specific Information:

Were you the: □ Driver □ Passenger □ Pedestrian □ Bicyclist

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender

Damage Amount Estimate: $_____ : □ Minor □ Major □ Totaled □ Moderate □ Unsure

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: □ Front □ Rear □ Pedestrian □ Driver Side □ Passenger Side □ Bumper □ Fender
□ Minor □ Major □ Totaled □ Moderate □ Unsure

Where did the accident happen? Street Names: _____ City/State _____

Was it? □ Controlled Intersection □ Uncontrolled □ Not Intersection

Was there a traffic light? □ None □ Green □ Red □ Turn Arrow □ Stop Sign

Were you: □ Slowly Moving □ Moving □ Stopped

Weather Conditions: □ Sunny □ Rainy □ Cloudy

Street Surface: □ Dry □ Wet □ Slick □ Icy □ Pavement □ Other _____

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Patient Questionnaire – Auto-Accident (cont'd)

Patient Name: _____DOB: _____Today's Date: _____

Auto-Accident Specific Information (cont'd)

Type of Impact: □ Rear end □ Front □ Side Impact □ Roll Over

Brakes on Impact: □ Locked Tight □ Loosely Applied □ Foot not on brake

How far did your car move? □ Did not move □ Moved 1-5 ft □ Moved 6-10 ft □ Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? □ Yes □ No

Shoulder harness: □ Yes □ No Headrest: □ Yes □ No Headrest Position: □ Up □ Down

Is the car equipped with airbags? □ Yes □ No Did they deploy? □ Yes □ No

Did you see the impact coming? □ Yes □ No Did you brace yourself for impact? □ Yes □ No

On impact, your head was looking: □ Ahead □ Behind □ Up □ Down □ To the Right □ To the Left

On impact were you: □ Thrown forward □ Thrown backwards □ Thrown sideways

□ Other _____

Did your body hit anything inside the car? □ Yes □ No Body Part: _____

What did it hit? _____

Head trauma? □ Yes □ No

Loss of Consciousness? □ Yes □ No For how long? _____

Do you remember the accident happening? □ Yes □ No

Hospital? □ Yes □ No

Name of hospital: _____ How long there? _____

Taken by ambulance? □ Yes □ No

X-rays taken? □ Yes □ No

X-ray areas: □ Neck □ Mid-back □ Low-back □ Other X-rays _____

Medication Given? □ Yes □ No

RX: _____

Other instruction: _____ Follow-up: _____

BRENNER
CHIROPRACTIC

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

I, _____, ("Assignor") hereby assign to **Brenner Chiropractic, P.C.** ("Assignee") all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

Brenner Chiropractic, P.C.
2468 N Jerusalem Rd.
Suite 15
Bellmore, NY 11710

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_____
(Signature of Provider)

_____
(Date of signature)

BRENNER
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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, muscle manipulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- ***Over-the-counter analgesics.*** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- ***Medical care,*** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- ***Hospitalization*** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- ***Surgery*** in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

BRENNER
CHIROPRACTIC

PATIENT AGREEMENT

I understand and agree that health 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 clearly understand and agree that all services rendered are charged directly 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.

_____ _____
Signature of Patient/Guardian Date

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the practice's "HIPAA Privacy Policy Notice", which describes the practice obligations to ensure the privacy of my health information. The HIPAA Privacy Policy Notice also describes how the practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the practice's HIPAA Privacy Policy Notice and to ask questions about it. I understand that the practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Policy Notice.

I further acknowledge that the practice can change its HIPAA Privacy Policy Notice in the future and that I can receive a copy of the practice's current Privacy Notice at any time.

I understand that I have the right to request that the practice restrict its use and disclosure of my health information for treatment, payment or health care operations. If my restrictions are accepted by the practice, these restrictions will be binding on the practice. I also understand that the practice is not required to agree to my requested restrictions.

I do not request any restrictions on the practice's use and disclosure of my health information for treatment, payment, or health care operations. _____ (Initial)

By signing this form, I consent to the practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at any time in writing, and if I do, my revocation will not affect any actions the practice has already taken in reliance of this consent.

_____ _____
Signature of Patient/Guardian Date

BRENNER
CHIROPRACTIC

2468 N Jerusalem Rd
Suite 15
Bellmore, NY 11710
Tel: (516) 208-6123
Fax: (516) 208-6122

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

To: _____

Address: _____

I, _____, hereby authorize the release of all records, examination results, x-rays, neurologic testing and any other diagnostic reports to be transferred to:

Brenner Chiropractic, P.C.
2468 N Jerusalem Rd
Suite 15
Bellmore, NY 11710
Phone: (516) 208-6123
Fax: (516) 208-6122

Patient Name: _____

Patient Signature: _____