



Dr. Alan Rosenthal, D.C., F.A.S.B.E.

**WHOLE HEALTH FAMILY CHIROPRACTIC**

712 N. Moorpark Road • Thousand Oaks, CA 91360  
Office (805) 449-0061 • www.WHFChiro.com

**CONFIDENTIAL PATIENT INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 City & State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 SS#: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: **M F** Marital Status: **S M W D**  
 Spouse's Name & Age: \_\_\_\_\_  
 Names of Children & Ages: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Have you ever been to a chiropractor before? \_\_\_\_\_ If so, when? \_\_\_\_\_

Circle your complaints and write how long you have had it.

Neck Pain/Stiffness _____	Rib Problems _____
Headaches _____	Low back Pain _____
Shoulder Pain _____	Hip/Groin Pain _____
Arm/Hand Pain _____	Leg Pain (R/L) _____
High/Low Blood Pressure _____	Dizziness _____
Allergies _____	Upper/Mid Back Pain _____

What type of care have you already received for your condition?

Chiropractic \_\_\_\_ Massage \_\_\_\_ Medication \_\_\_\_ Surgery \_\_\_\_ Other \_\_\_\_\_

Name of Doctor(s) who have cared for you: \_\_\_\_\_

Circle any conditions you have currently or previously had.

AIDS/HIV	Arthritis	Asthma	Anemia	Anorexia
Appendicitis	Bulimia	Cancer	Bleeding	Breast Lump
Bronchitis	Diabetes	Emphysema	Cataracts	Chemical Dependand
Chicken Pox	Goiter	Gonorrhea	Epilepsy	Fractures
Glaucoma	Hernia	Herniated Disc	Gout	Heart Disease
Hepatitis	Liver Disease	Measles	Herpes	High Cholesterol
Kidney Disease	MS	Mumps	Osteoporosis	Miscarriage
Mono	Pinched Nerve	Pneumonia	Polio	Pacemaker
Parkinson's	Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever	Prostate Problem
Stroke	Suicide Attempt	Thyroid Problems	Tonsillitis	Scarlet Fever
Tumors, growths	Typhoid Fever	Ulcers	Vaginal Infections	Vision Problems
Fibromyalgia	Migraine	Cold/Flu	Viral Infections	TB
Whooping Cough	Vision Problems	Ear Infections	Other _____	



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## PERSONAL INJURY HISTORY INTAKE

Full legal name: \_\_\_\_\_ Date: \_\_\_\_\_

### ACCIDENT INFORMATION

Automobile/ Motorcycle/ Slip and fall/ Other

Driver / Passenger

Date of accident: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Thorough description of accident:

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Did you experience pain immediately after the accident? Yes / No , if so, where?

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First onset of pain? Few hours later / Next day / A few days later

Where? \_\_\_\_\_

Was the police notified? Yes / No Was a report taken? Yes / No

Where did you go after the accident? Home Doctor Work Other

If you went to the hospital, were you transported by the ambulance? Yes / No

What type of treatment so far for this injury? Medical / Chiropractic / Other

Were you prescribed any medication(s)? Yes / No

Any x-rays taken: Yes / No What area(s): \_\_\_\_\_

Date and name of doctors / hospitals/ medical facilities you received treatment for this accident:

Date: \_\_\_\_\_ Name of facility: \_\_\_\_\_

Date: \_\_\_\_\_ Name of facility: \_\_\_\_\_

Date: \_\_\_\_\_ Name of facility: \_\_\_\_\_

Are you currently working? Yes / No

Employer? \_\_\_\_\_ Job title: \_\_\_\_\_

Have you lost time from work since the accident? Yes / No

How much time lost: \_\_\_\_\_ hrs \_\_\_\_\_ day(s)

Have you been able to perform your regular job duties? Yes / No



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If no, explain: \_\_\_\_\_

Did you have any physical complaints before the accident? Yes / No

If yes, please describe: \_\_\_\_\_

Please state month, year, brief description and body part for the following:

Illnesses? \_\_\_\_\_

Previous injuries/car accidents? \_\_\_\_\_

Surgeries? \_\_\_\_\_

Fractures/Broken bones? \_\_\_\_\_

Do you smoke? Yes / No Do you drink alcohol? Yes / No Heavy / Moderate /  
Social / Rare

### **Please answer these questions:**

Were you aware of the collision? Yes / No

Did your body move: Forward and back / Back and forward/ left to right/ right to left

Were you wearing a seat belt? Yes / No

Were you able to exit the vehicle on your own? Yes / No

Did the airbags deploy? Yes / No

Did any of you body part(s) hit any interior part of the vehicle? Yes / No

If yes, which body part of your body? \_\_\_\_\_

Which part of the vehicle did you hit? \_\_\_\_\_

Did this accident cause another collision? Yes / No

Did you lose consciousness? Yes / No

### **Attorney information:**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_



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**TERMS OF ACCEPTANCE**

When a patient seeks chiropractic health care and we will accept patient for such care, it is essential for both to be working towards the same objective.

**Chiropractic** has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the  
(print name)  
above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore, I accept chiropractic care on this basis.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



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### Informed Consent to Chiropractic Care

*Patient: Please discuss any questions or concerns with the doctor before signing this consent.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by Dr. Alan Rosenthal, his staff, and/or his associates.

#### **The Nature of The Chiropractic Adjustment**

I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “pop” your knuckles. You may feel a sense of movement.

#### **The Material Risks Inherent with The Chiropractic Adjustment**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

#### **The Probability of Those Risks Occurring**

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as “rare”.

#### **Ancillary Treatment**

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

- Heat ~ risk of 1<sup>st</sup> and 2<sup>nd</sup> degree burns, hemorrhage
- Cryotherapy (cold packs) ~ risk of skin reactions
- Trigger Point Therapy ~ risk of bruising, release of emboli
- Massage ~ risk of deep vein thrombosis

#### **The Availability and Nature of Other Treatment Options**

- Other treatment options for your condition may include:
- Self-administered over-the-counter analgesics and rest
  - Medical care with prescription drugs
  - Hospitalization
  - Surgery



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### **The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:**

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

### **The Risks and Dangers Attendant To Remaining Untreated**

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient



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### Patient Acknowledgement of Privacy

**I acknowledge that I have read and fully understand the the Notice of Privacy Practices of Whole Health Family Chiropractic. I understand that I may request a copy of this notice at any time. I further understand that this Notice may be modified with no prior notification to me.**

\_\_\_\_\_  
Print Full Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative (If signing for a minor I have authority to do so)



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**AUTHORIZATION OF DIRECT PAYMENT AND IRREVOCABLE DOCTOR'S LIEN**

TO: \_\_\_\_\_ PATIENT: \_\_\_\_\_  
\_\_\_\_\_  
DATE OF ACCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ office  
\_\_\_\_\_ fax

I do hereby authorize **Dr. Alan Rosenthal, D.C.**, to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical services rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and full compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may be eventually recover said fee.

I agree to promptly notify said doctor of any change or addition to attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

\_\_\_\_\_  
Date Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

\_\_\_\_\_  
Date Attorney Signature



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TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_office  
\_\_\_\_\_fax

PATIENT: \_\_\_\_\_  
DATE OF ACCIDENT: \_\_\_\_\_

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Attorney Signature



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**Personal Injury Liability/Financial Agreement**

**Patient Name** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_

We would like to take a moment and welcome you to our office. We can assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office I would like to explain how your medical billing will be managed.

**Police Report Number** \_\_\_\_\_ **Copy Attached** Y/N

Were you at fault? Y/N. If yes, please enter only your vehicle information (Section 1)

**1) Patient Vehicle**

We will bill your automobile insurance if you have Medical Coverage on your policy.

After your treatment, the responsible party (if any) will directly reimburse your automobile insurance company. *(This will not increase your premium)*

Your Insurance Co. \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim: \_\_\_\_\_

Address: \_\_\_\_\_

Adjustor: \_\_\_\_\_ Phone: \_\_\_\_\_

Med Pay Amount \$ \_\_\_\_\_

Uninsured Motorist Claim Limits \$ \_\_\_\_\_

**2) Responsible Party**

*Please note:* most 3<sup>rd</sup> party insurance companies will pay the injured party (you) directly once treatment is completed and billing is received.

If your claim is a 3<sup>rd</sup> party claim, we will send all billing to the insurance company once we receive payment from you for all the services rendered. We accept cash, check or credit card. You will be reimbursed by the insurance company.

Once you receive the settlement payment, be sure that you make all necessary medical payments (e.g. chiropractic care, ambulance, hospital, other medical care) that were rendered to you during your personal injury treatments. At that time, we will charge your credit card(s) and/or deposit your check.



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Our staff will be following up with the insurance company to ensure that you have received your settlement.

Policy Holder Name: \_\_\_\_\_

Insurance \_\_\_\_\_ Policy/Claim \_\_\_\_\_

Address \_\_\_\_\_

Adjustor \_\_\_\_\_ Phone \_\_\_\_\_

**3) Attorney Information** If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any **balance** upon the settlement of your law suit. Furthermore, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Attorney \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### **4) Health Insurance**

Insurance Company \_\_\_\_\_ Policy \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Coverage Amount \_\_\_\_\_

As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, **you are personally responsible for payment of these charges**, regardless of any insurance reimbursement or settlement you may not receive.

Patient Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Name (print) \_\_\_\_\_



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**RECISSION OF ATTORNEY ASSIGNMENT OF BENEFITS**

PATIENT: \_\_\_\_\_

INSURED: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

CLAIM # / POLICY #: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you and any third party including my attorney, except to my physician:

DR. ALAN ROSENTHAL, D.C.  
**WHOLE HEALTH FAMILY CHIROPRACTIC**  
**712 N. MOORPARK ROAD**  
**THOUSAND OAKS, CA 91360**  
**TEL: (805) 449-0061, FAX: (805) 449-0014**

As the owner and beneficiary of this policy, I further direct that reimbursement of ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bills, except the treating physician for the remainder of this claim.

Thank you for your cooperation in this matter.

\_\_\_\_\_  
Patient: Insured Signature

\_\_\_\_\_  
Date



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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

To: \_\_\_\_\_

Address: \_\_\_\_\_

Please release the following information to:

**Dr. Alan Rosenthal, D.C., F.A.S.B.E.**  
712 N. Moorpark Rd.  
Thousand Oaks, CA 91360  
(805) 449-0061  
(805) 449-0014 fax

\_\_\_ X-Rays \_\_\_ History \_\_\_ Records \_\_\_ Diagnosis \_\_\_ Treatment \_\_\_ Reports

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_