Welcome to Webster Family Chiropractic!

We are dedicated to providing the highest quality family chiropractic health care and education in a caring atmosphere. It is our honor and pleasure to serve you.

What to Expect

Today you will complete important paperwork and receive a thorough consultation and doctor recommended examinations for your particular needs. This is the day we gather the information that is necessary to give you the highest quality of care.

Scheduling the next two visits will be the last part of today's visit, if you and the Doctor elect to work together for your better health.

Day Two the Doctor will provide you with a complete report of your exam findings. You will then receive your first gentle chiropractic adjustment.

Day Three the Doctor will evaluate your body's response to your chiropractic adjustment. The next step is to outline the best recommendations for correcting your problem and the choices that are available to you. You are welcome and encouraged to bring your spouse or significant other. This is the day for making your healthcare decisions and determining the financial options that are best suited for you.

X_____

Dr. Shari R. Webster, D.C.
16515 S. 40th St.
Suite 103
Phoenix, Arizona 85048
(480) 785-1351

Patient Case History

HIPAA
Protected Health Information
Authorized Access Only

CONFIDENTIAL

Date _____ Case # _____

Patient/Clinic I.D. # _____ Driver's License # _____

Name _____ Social Security # _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Insurance Co. _____ Insurance Phone _____

Sex ❑M ❑F Age ___ Date of Birth _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Occupation _____ Shift 1 2 3 Description _____

Employer _____ Work Phone _____ Ext. _____

Work Address _____ Years Worked _____

Spouse _____ List Children _____

Spouse's Social Security _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone _____ Ext. _____

Spouse's Insurance _____ Spouse's Insurance Phone _____

Last Doctor's Name _____ List Medications _____

Care Received _____ List Surgeries _____

Results _____

Are your present problems due to an injury? ❑ Yes ❑ No ❑ On the Job ❑ Auto Collision ❑ Personal Injury ❑ Other

Have you made a report of your accident? ❑ Yes ❑ No ❑ To Employer ❑ Auto Carrier ❑ Other _____

Has the accident been reported? ❑ Yes ❑ No ❑ Workers' Comp ❑ Auto Carrier ❑ Other _____

Are you now or have you ever been disabled/impaired? (Service or Work?) ❑ Yes ❑ No When _____

Have you retained an attorney? ❑ Yes ❑ No Name & Address _____

CHIEF COMPLAINT / REGIONS OF PAIN

1) _____

2) _____

3) _____

4) _____

HABITS

❑ Smoking Packs/Day _____

❑ Alcohol Cups/Day _____

❑ Coffee Cups/Day _____

❑ Soda Pop Cups/Day _____

EXERCISE

❑ None

❑ Moderate

❑ Daily

Type _____

SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

MARK PAIN REGION

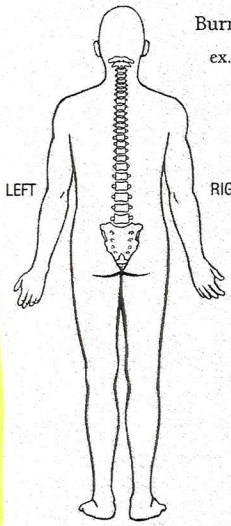
Burning • Stabbing • Sharp • Constant

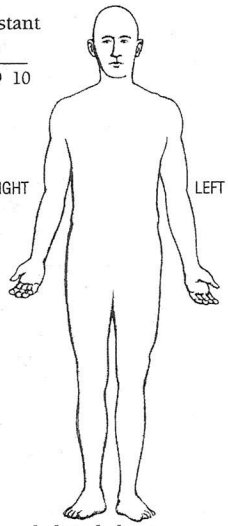
ex. Neck _____ sharp

1 2 3 4 5 6 7 (8) 9 10

MARK PAIN AREA

+++ Burning
000 Stabbing
--- Sharp
||| Constant
XXX Other





REGIONS

Neck _____
1 2 3 4 5 6 7 8 9 10

Mid Back _____
1 2 3 4 5 6 7 8 9 10

Low Back _____
1 2 3 4 5 6 7 8 9 10

Hips _____
1 2 3 4 5 6 7 8 9 10

Arms _____
1 2 3 4 5 6 7 8 9 10

Legs _____
1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the code listed above.

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑ 303.9 Alcoholism	❑ 345. Epilepsy	❑ 072. Mumps
❑ 280. Anemia	❑ 240. Goiter	❑ 511. Pleurisy
❑ 541. Appendicitis	❑ 429.9 Heart Disease	❑ 480. Pneumonia
❑ 716. Arthritis	❑ 042. HIV Positive	❑ 045. Polio
❑ 239. Cancer	❑ 487. Influenza	❑ 390. Rheumatic Fever
❑ 052. Chicken Pox	❑ 724.2 Low Back Pain	❑ 737.30 Scoliosis
❑ 250. Diabetes	❑ 055. Measles	❑ 846. Sprain/Strain Sacroiliac
❑ 690. Eczema	❑ 319. Mental Disorder	❑ 847.0 Whiplash

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother – Living Y❑ N❑	❑	❑	❑	❑	❑
Father – Living Y❑ N❑	❑	❑	❑	❑	❑
Brother(s), # of ____	❑	❑	❑	❑	❑
Sister(s), # of ____	❑	❑	❑	❑	❑
Adoption History	❑	❑	❑	❑	❑

OFFICE USE ONLY

Patient's Last Physical _____

Patient's Last Lab _____

Patient's Last X-ray _____

Patient's Prostate Exam _____

Patient's Last Pap Smear _____

Patient's Last Breast Exam _____

Patient's Last Spinal Exam _____

Patient's Last Spinal X-ray _____

Patient's Last EMG _____

Patient's Last Infrared Thermography _____

Patient's Last Disc Exam _____

Patient's Last MRI _____ CT Scan _____

Notes _____

PATIENT CASE HISTORY

106g

CONFIDENTIAL

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable.
A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS

____ 784.0 Headache
____ 780.6 Fever
____ 780.99 Chills
____ 780.8 Night Sweats
____ 780.2 Fainting
____ 780.4 Dizziness
____ 780.3 Convulsions
____ 780.52 Loss of Sleep
____ 780.7 Fatigue
____ 799.2 Nervousness
____ 783. Loss of Weight
____ 782. Numbness or pain in arms/legs/hands
____ 995.3 Allergy (What)
____ 786.07 Wheezing
____ 729.2 Neuralgia

MUSCLES & JOINTS

____ 728.9 Weakness
____ 781.0 Twitching
____ 723.5 Stiff Neck
____ 724.5 Backache
____ 719.0 Swollen Joints
____ 781. Tremors
____ 729.5 Foot Trouble
____ 724.79 Painful Tail Bone
____ 724.5 Pain Between Shoulders
____ 737.3 Spinal Curvature

GASTRO-INTESTINAL

____ 783. Poor Appetite
____ 536.8 Poor Digestion
____ 994.2 Starvation
____ 787.3 Belching or Gas
____ 787.0 Nausea
____ 787.0 Vomiting
____ 578.0 Vomiting Blood
____ 536.8 Pain over Stomach
____ 564.0 Constipation
____ 787.91 Diarrhea
____ 562.1 Colon Trouble
____ 455.6 Hemorrhoids (Piles)
____ 776.7 Fluid Retention
____ 873.9 Liver Trouble
____ 274. Gout
____ 782.4 Jaundice
____ 575.9 Gall Bladder Trouble

CARDIO–VASCULAR

____ 785.0 Rapid Heart
____ 427.89 Slow Heart
____ 401.9 High Blood Pressure
____ 458.9 Low Blood Pressure
____ 786.51 Pain Over Heart
____ 429.9 Heart Trouble
____ 719.07 Swelling Ankles
____ 459.9 Poor Circulation
____ 454.9 Varicose Veins
____ 436. Strokes
____ 785.1 Palpitations

EYE/EAR/NOSE/THROAT

____ 368.9 Poor Vision
____ 378.0 Crossed Eyes
____ 379.91 Pain in Eyes
____ 389.9 Deafness
____ 388.70 Earache
____ 388.30 Ear Noises
____ 388.60 Ear Discharges
____ 478.1 Nasal Obstruction
____ 784.7 Nose Bleeds
____ 462. Sore Throats
____ 784.49 Hoarseness
____ 477.9 Hay Fever
____ 493.9 Asthma
____ 460. Frequent Colds
____ 240.9 Enlarged Thyroid
____ 463. Tonsillitis
____ 473. Sinus Trouble

SKIN OR ALLERGIES

____ 680. Skin Eruptions – No
____ 698.9 Itching
____ 924.9 Bruising Easily
____ 701.1 Dryness
____ 680.9 Boils
____ 782. Sensitive Skin
____ 708.9 Hives or Allergy
____ 692.9 Eczema
____ Medicines
_____
_____
_____

RESPIRATORY

____ 786.2 Chronic Cough
____ 786.3 Spitting Blood
____ 786.4 Spitting Phlegm
____ 786.50 Chest Pain
____ 786.09 Difficulty Breathing

GENITO-URINARY

____ 788.4 Frequent Urination
____ 788.1 Painful Urination
____ 599.7 Blood in Urine
____ 590. Kidney Infection
____ 788.3 Bed Wetting
____ 788.3 Inability to control Urine
____ 601.9 Prostate Trouble

FOR WOMEN ONLY

____ 625.3 Painful Periods
____ 626.2 Excessive Flow
____ 626.4 Irregular Cycle
____ 627.2 Hot Flashes
____ 625.3 Cramps or Backaches
____ 623.5 Vaginal Discharge
____ Pregnant at this Time
____ Last Pap
By Whom _____
Other _____

IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES – HOSPITALIZATION

DATE		DATE		DATE		DATE	
_____	Vaccinations	_____	Other	_____	Rectal Surgery	_____	Thyroid
_____	Tonsillectomy	_____	Tubes in Ears	_____	Other	_____	Stomach
_____	Gall Bladder	_____	Appendectomy	_____	Sinus	_____	Other
_____	Back Operation	_____	Female Organs	_____	Hernia		

Hospital Stays _____
Other Surgeries _____

List any accidents or falls/list dates: ❑ Car _____ ❑ Recreational Vehicle _____ ❑ Sports _____
❑ School _____ ❑ Other _____

List any broken bones (fractures) or dislocations: _____
Have you ever been on crutches? ❑ Yes ❑ No Why? _____
Have you ever had a lapse of memory? ❑ Yes ❑ No Have you ever been unconscious? ❑ Yes ❑ No
Have you ever had X-rays taken? ❑ Yes ❑ No When? _____ By Whom? _____
For what ailments were these X-rays made? _____
Do you suffer from any condition other than that for which you are now consulting us? _____
Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No List: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me 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 me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file and x-rays upon request. Copying fees may apply.

Patient Signature _____ *Date* _____
Guardian Signature _____ *Date* _____
Doctor Signature _____ *Date* _____

PATIENT CASE HISTORY

Patient Examination

CONFIDENTIAL

Date _____ Clinic _____

Patient _____

Patient/Clinic I.D. # _____

HIPAA
Protected Health Information
Authorized Access Only

Date of Birth _____ Social Security # _____

Ambulates: ❑ Normal ❑ Impaired ❑ Difficult ❑ Assistance **Height:** _____ **Weight:** _____

❑ Cane/Crutch ❑ Walker ❑ Pain

Dominant Hand: ❑ Rt ❑ Lt **Grip:** ❑ Right ____ ❑ Left ____

Complaints _____

Body Type: ❑ Ectomorph ❑ Endomorph ❑ Mesomorph

❑ Obese ❑ Gracile Habitus

Gait: ❑ Normal ❑ Limp ❑ Right ❑ Left

❑ Walk Toe In ❑ Walk Toe Out

New Patient 99201 _____

❑ **Sprain:** Region _____

Established Patient 99211 _____

❑ **Strain:** Region _____

PHASE 1 ❑

N.P.T. 99202 • E.P.T. 99212

SPINAL EXAMINATION AND ANALYSIS

Biomechanical or Graph	Palpitation	Spasm	X-ray
Occ	Occ	Occ	Occ
At	At	At	At
Ax	Ax	Ax	Ax
3C	3C	3C	3C
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
1D	1D	1D	1D
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9
10	10	10	10
11	11	11	11
12	12	12	12
13	13	13	13
1L	1L	1L	1L
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
Sac	Sac	Sac	Sac
Coc	Coc	Coc	Coc
Rt Hip	Rt Hip	Rt Hip	Rt Hip
Lt Hip	Lt Hip	Lt Hip	Lt Hip

PHASE 2 ❑

N.P.T. 99202 – 99203 • E.P.T. 99213

George's Test _____

P _____ BP _____ Respiration _____

VISUAL POSTURE ANALYSIS A-P

Head Tilt	RT	LT	R. Ear	Hi	Lo
R. Shoulder	Hi	Lo	Scapula	Hi	Lo
R. Ilium	Hi	Lo	LAT:		

Head Carried _____

Cervical Spine _____ Curve

Dorsal Spine _____ Curve

Lumbar Spine _____ Curve

Areas of Muscle Spasm C _____

D _____ L _____ P _____

RANGE OF MOTION

Cervical	L	R	Lum. Dor.	L	R
Fix (65)			Fix (95)		
Ext (50)			Ext (35)		
L.F. (40)			L.F. (40)		
Rot (55)			Rot (35)		

Dynagrip R _____ L _____

Other Tests _____

Note: All Phases (1, 2, 3 & 4) are recommended for CPT Codes 99205 - 99215 (Complete Phases 1, 2, 3, & 4)

PATIENT EXAMINATION

CONFIDENTIAL

PHASE 3 ❑

N.P.T. 99204 – 99205 • E.P.T. 99214 – 99215

	LEFT	RIGHT
Foramina Compression		
Shoulder Depression		
Distraction		
Valsalva's		
Derifield	C \ P	C \ P
Ely's		
Soto Hall		
Laseque		
Braggard's		
Fabere-Patrick's		
Bilateral Leg Raise		
Fajersztajn		
Trendelenberg		
Adam's Sign		
Romberg's		
Minor's		
Kemp's		
Other _____		

PHASE 4 ❑

Additional Tests

_____

Dr. Comments _____

X-rays Ordered _____

Note: All Phases (1, 2, 3 & 4) are recommended for CPT Codes 99205 - 99215 (Complete Phases 1, 2, 3, & 4)

CONSENT TO X-RAY

Patient Name _____

I hereby authorize Dr. _____ and whomever he/she designates as his/her assistant(s) to take X-rays of myself (or said minor).

Dated this _____ day of _____, 20 ____.

Witness _____
Printed Name

_____
Signature

Patient _____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if Patient is a Minor)

PREGNANCY WARNING

Patient Name _____ Date _____

❑ I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

❑ I have been advised that the 10 days following the onset of a menstrual period are generally considered to be safe for X-ray examination.

With those factors in mind, I am advising my doctor that:

I am pregnant:	❑ Yes	❑ No	❑ Don't know
I could be pregnant:	❑ Yes	❑ No	❑ Don't know
I have an IUD:	❑ Yes	❑ No	❑ Don't know
I have had a tubal ligation:	❑ Yes	❑ No	❑ Don't know
I am late with my menstrual period:	❑ Yes	❑ No	❑ Don't know
I am taking oral contraceptives:	❑ Yes	❑ No	❑ Don't know
I have had a hysterectomy:	❑ Yes	❑ No	❑ Don't know
I have irregular menstrual periods:	❑ Yes	❑ No	❑ Don't know

My last menstrual period began on: _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

AUTHORIZATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me 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 me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat any condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

_____ _____
Patient Signature *Date*

_____ _____
Guardian or Parent Signature Authorizing Care *Date*

PATIENT EXAMINATION

Shari R. Webster, D.C.
16515 S. 40th St. Suite 103
Phoenix, Arizona 85048
P: (480) 785-1351
F: (480) 785-1647

Provider Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosure of Health Information:

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of the treatment and your records may be shared by paper mail, electronic mail, fax or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any further uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area you can also request a copy of our notice at any time. For more information about our privacy practices, contact the Privacy Officer.

Individual Rights:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge a medical records copy fee of $40.00. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the US Department of Health and Human Services.

Our Legal Duty:

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practiced that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Privacy Officer: Shari R. Webster, D.C.
16515 S. 40th St. Suite 103
Phoenix, Arizona 85048
(480) 785-1351

Acknowledgement of receipt of Notice and Privacy Practices:

Please sign your name and print your name and date on this acknowledgment form. If you would like a copy, please ask for one.

Signature: _____

Print Name: _____

Date: _____

DIAGNOSTIC X-RAY CONSULTATION SERVICES®

GARY A. LONGMUIR, M.App.Sc., D.C., D.A.C.B.R.
Radiology

Diplomate, American Chiropractic Board of Radiology
Fellow, the American Chiropractic College of Radiology

2525 West Carefree Highway, Building 2A. Suite 114
Phoenix, AZ 85085-9302
Telephone: (602) 274-3331
Fax: (602) 279-4445
www.diagnosticx-ray.com

PATIENT AUTHORIZATION AND ASSIGNMENT

I consent that my x-rays will be interpreted by Dr. Gary A. Longmuir, chiropractic radiologist, and that a formal written report will be issued to my physician's office to become part of my permanent treatment record. I understand that all charges from this consultation are ultimately my responsibility and separate from any charges at my Physician's office.

I authorize the release of any medical information necessary to process this claim. I also authorize the direct payment of medical benefits from group health, medical payments or third party payor to the physician for services described above. In the event that payment is not made on this account and it is placed with a licensed collection agency, I agree to pay collection agency fees up to a maximum of 21% of the outstanding balance at the time the account is placed with the agency. Should legal action be necessary to collect the account, I agree to pay attorney's fees and court cost incurred for collection.

Date_____ **Patient's Signature** _____
(Parent or guardian if minor child)

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the x-ray examination of myself in regard to the accident in which I was 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 medical service rendered me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case 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 said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

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 but will require me to pay on my account and keep it on a current basis.

Dated_____ **Patient's Signature**_____
(Parent or guardian if minor child)

Patient's Name_____
(Please print)

The undersigned being attorney of record for the above patient does hereby agrees to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said doctor named above.

Dated_____ **Attorney's Signature**_____

Please date, sign and return one copy to doctor's office.

Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.