ESTNER
INJURY CENTERS
Chiropractic | Physiotherapy

e: contact@DrEstner.com w: DrEstner.com

PATIENT INFORMATION

Date: _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Sex: M____ F____ X____

Age: ____ Height: _____ Weight: _____ DOB: _____

Occupation: _____ Employer: _____

Primary Dr.:_____

PRIVACY POLICY

All patient information is confidential. Every attempt will be made to respect confidentiality when communicating. Privacy policy is posted in each office. Patient information will be released with signed consent. Family members/friends are not permitted to obtain any personal information without signed consent. Employees of Estner Injury Centers have reviewed this privacy policy.

PERMISSION OF CORRESPONDENCE:

- I grant permission to receive appointment text reminders
- I grant permission to leave a voicemail on my phone
- I grant permission to be contacted regarding test results, confirmation of appointments and insurance
- I grant permission to communicate with the office via text and phone

_____

Signature of Patient **Date:**

_____

(Minors) Parent/Legally Authorized Representative Relationship to Patient Date:

WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec.# _____

Address _____
Street City State Zip

Home Phone (____) _____ E-mail _____

Cell Phone (____) _____ Occupation _____

EMPLOYER

Employer Name _____

Employer Address _____
Street City State Zip

Employer Phone (____) _____ Injury Verified by (For Office Use) _____

Contact Person _____ E-mail _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____

Carrier Address _____
Street City State Zip

Carrier Phone (____) _____ Coverage Verified by _____

Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ ☐ AM ☐ PM Place of Injury _____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to _____

Give full description of how accident happened _____

_____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much? _____

Other doctors seen for this condition: Doctor's Name _____

Diagnosis _____ Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s) _____

_____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries _____

Describe previous Worker Compensation injuries _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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AUTHORIZATION FOR THE RELEASE OF INFORMATION

TO_____

_____

Patient Name **Record Number** **Date of Birth**

_____

__ I authorize_____ to: _X_ I authorize the facsimile transmission of the above records.

__ Obtain information from my medical record from: Fax # _____

__ Release information from my medical record to: Date Transmitted _____

_____

Name Phone Number

_____

Address City State Zip

_____

Please release the following information from my medical record: Date(s) of service_____

_X_ All pertinent information

_X_ Medical Records + Radiology Reports

___ Other: _____

The purpose of this request is for: (please check ALL that apply)

__ Further Medical Care __ Legal __ Insurance __ Disability/ Workman's Comp. __ Radiology __ Other

_____

I understand that this authorization shall expire, without my express revocation, six (6) months from the date written below. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____

Signature of Patient Date

_____

Parent/Legally Authorized Representative Relationship to Patient Date

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Informed Consent

Patient Name: _____ **Date:** _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The Primary treatment used by Doctor of Chiropractic is spinal manipulative therapy. Dr. Estner and/or associates may use his/her hands or a mechanical instrument in such a way as to realign the joints. This may cause an audible "pop" similar to the noise when you crack your knuckles.

The material risks inherent in a chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to serious complications including stroke. Other types of complications include but are not limited to the following: fractures, disk injuries, dislocations, muscle strain, cervical myelopathy (nerve injury) and burns. Some patients will feel some stiffness and soreness following the first few days of treatment, this is normal.

The doctor will make every reasonable effort during examination to screen for contraindications to receiving care; however, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

I have read the above explanation of the chiropractic adjustment and related risks. I have discussed this document with Dr. Estner and/or associates and have had my questions answered to my satisfaction. By signing below, I have weighed the risks involving and undergoing treatment and have decided that it is my best interest to undergo the recommended treatment.

Signature: _____