DAVID M. ISRAEL, D.C.

IN PULSE CHIROPRACTIC, P.C.

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CONSENT TO TREATMENT OF MINOR

I hereby authorize *David M. Israel, D.C.* and whomever he may designate as assistants to administer treatment as deemed necessary to my son / daughter / other _____ (Indicate relationship of patent).

_____
Name of minor

This _____ day of _____, 2_____.

Parent / Guardian Name: _____
Printed Name

_____
Signature

Parent / Guardian Phone Number: _____

IMMEDIATELY UPON COMPLETION PLEASE MAIL COPIES AS SHOWN BELOW

WORKER'S & PHYSICIAN'S REPORT OF INJURY

INDUSTRIAL COMMISSION OF ARIZONA

P.O. BOX 19070 • PHOENIX, ARIZONA 85005

INJURED WORKER'S RIGHT TO CHOOSE DOCTOR

An employer who is not self insured can direct you to a doctor of their choice for ONE visit. After the **ONE** visit, you may report to a doctor of your choice. **REMEMBER:** If you make a **SECOND** visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self insured, you may not be allowed to change doctors. **SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.**

WORKER'S REPORT

NAME OF INJURED WORKER — LAST NAME / FIRST / M.I. _____ SOCIAL SECURITY NO. _____ PHONE NO. _____

I C A USE ONLY

INJURY CODE: _____

1. _____

2. ADDRESS _____ CITY _____ STATE _____ ZIP _____

3. DATE OF BIRTH (MO. DAY YR.) _____ 4. SEX: MALE ☐ FEMALE ☐

5. SINGLE ☐ WIDOWED ☐ DIVORCED ☐ MARRIED ☐ IF SO, IS SPOUSE EMPLOYED YES ☐ NO ☐

6. OCCUPATION WHEN INJURED _____ DATE OF INJURY (MO. DAY YR.) _____ TIME OF INJURY _____ A.M. P.M.

7. EMPLOYER'S NAME _____ PHONE NO. _____

8. OFFICE ADDRESS _____ CITY _____ STATE _____ ZIP _____

9. EMPLOYER'S INSURANCE CARRIER _____ POLICY NO. _____

10. MAILING ADDRESS _____

11. DESCRIBE WHERE AND HOW ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT) _____

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS. FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.

DATE OF SIGNING (MO. DAY YR.) _____ AT CITY _____ STATE _____

IMPORTANT: INJURED WORKER'S SIGNATURE REQUIRED HERE X _____

PHYSICIAN'S INITIAL REPORT

12. DATE FIRST TREATMENT (MO. DAY YR.) _____ HOUR _____ A.M. P.M. 13. LOCATION: HOSPITAL ☐ OFFICE ☐ OTHER ☐ _____

14 DATE WORKING DISABILITY BEGAN (MO. DAY YR.) _____ 15. WHO ENGAGED YOUR SERVICES? PATIENT ☐ EMPLOYER ☐ OTHER ☐ _____

16. WAS PATIENT TREATED BY ANYONE ELSE? YES ☐ NO ☐ IF YES, BY WHOM _____

17. COMPLAINTS AND PHYSICAL FINDINGS, IN DETAIL:

18. ICD-9 CODE _____ : DIAGNOSIS:

19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION _____

20. PATIENT IS RIGHT ☐ LEFT ☐ HANDED

21. DESCRIBE TREATMENT GIVEN BY YOU:

22. WERE X-RAYS TAKEN? YES ☐ NO ☐ IF YES, BY WHOM _____ WHEN (MO. DAY YR.) _____

23. WAS LABORATORY WORK DONE? YES ☐ NO ☐ IF YES, BY WHOM _____ WHEN (MO. DAY YR.) _____

24. X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM)

25. WAS PATIENT HOSPITALIZED? YES ☐ NO ☐ IF YES, WHERE _____

26. DATE OF ADMISSION TO HOSPITAL (MO. DAY YEAR) _____ 27. DATE OF DISCHARGE (MO. DAY YEAR) _____

28. IS FURTHER TREATMENT NEEDED? YES ☐ NO ☐ IF YES, FOR HOW LONG _____

29. IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OR IMPAIRMENT? YES ☐ NO ☐

(B) ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT TIME OF INJURY? YES ☐ NO ☐ IF YES, DATE ABLE (MO. DAY YR.) _____ IF NOT, ANTICIPATED DATE (MO. DAY YR.) _____

(C) ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES ☐ NO ☐ IF YES, DATE ABLE _____

IF NOT, ANTICIPATED DATE ABLE (MO. DAY YR.) _____

30. REMARKS:

NAME OF PHYSICIAN _____ BILLING CODE NO. _____

ADDRESS _____ ZIP _____ PHONE _____

IRS. NO. _____ PROFESSIONAL CORP? YES ☐ NO ☐

DATE OF THIS REPORT (MO. DAY YR.) _____ PHYSICIAN'S SIGNATURE REQUIRED HERE X _____