

5940 W. Union Hills Dr. #A140 Glendale, AZ 85308 Ph. 602-377-2206

DateWhom	n may we thank fo	or referring you	to us?				
Patient Name	Date of Birth		Age	Gender:	M	F	
Address							
City	State	Zip					
Cell Phone	Home		Preferred	l Phone: Ho	me /	Cell	
E-mail Address							
Would you like a reminder vi	a TEXT or EMAI	L? TEXT / E	MAIL (circle	e one)			
Emergency Contact	Relationship		Phone #				
Primary Insurance Company		Insuran	ace ID #				
Group #In	sured's Name(If n	ot self)					
Secondary InsuranceCompan	у	Ins	surance ID #_				
Group #I	nsured's Name (If	not self)					
Assignment and Release I, the undersigned, assign directly t services rendered. I understand that hereby authorize the doctor to releasuse of this signature on all insurance payment, all costs of collections (no court costs, plus interest, shall be the	t I am financially responder all information necessitions and the submissions. Patient to exceed 50% of the submissions are submissions.	consible for all char cessary to secure that Responsible pane are outstanding bal	arges whether or he payment of b rty agrees that in	not paid by in enefits. I auth n the event of i	suranc orize tl non-	e. I he	

Date

Patient signature/Responsible party signature



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iaw nain		0 1 2	5 4	5	р	7	8	9	10		
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low back pain		wnat percen	tage of ti	me o	io you	expe	erien	ce in	e pain	r	%
elbow pain	hip pain	14/00 4	h!	al.			ـــ ــ امام	2 /-:-		-1	
knee pain	other	was t	he pain	grad	uai o	r su	aaen	ı? (cir	cie on	e)	
What aggrava	tes the pain? (circle)	What relie	ves the	paiı	n? (d	circle	<u>e)</u>				
sitting	neck movement	res	t		ma	ssage	!				
walking	movement at waist	ice			wa	lking					
running	any movement	hea	at		pai	n med	dicati	ion			
lifting	standing	stre	etching		mu	scle r	elaxe	ers			
driving	standing from seated position	n exe	ercise		not	hing					
other		oth	er								
Type of Pain ((circle)	When is pa	ain wor	se?	(circ	le)					
		morning						night	t		
		all the time				_		_			
			30.101								
Does the pain	radiate? (circle)	How long	have yo	ou b	een (expe	rien	cing	this	symp	tom
arm leg	other										
										•	
		Rate the p								one)	
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Health History

Have you ever been hospita	alized? If yes, what	t/when?				
Have you had any major su	argeries in the last 1	0 years?				
Have you ever had any broken bones? If yes, what/when?						
Have you had any recent injuries?						
Are you currently taking ar	ny medications or si	upplements? If yes,	what?			
Do you consume soda, coff	fee or alcohol?					
Do you exercise/stretch reg	gularly?					
When was your last physical	al exam?					
Are you pregnant?			How far along?			
		Family Histo	ory			
Please indicate if any of the	he following condi	tions run in your fa	amily:			
Anemia	Arteriosclerosis	Arthritis	Bleed easily	Cancer		
Diabetes	Emphysema	Epilepsy	Heart Disease	High BP		
High Cholesterol	Multiple Sclerosis	Osteoporosis	Stroke	Thyroid Disease		
Do you have any other h	ealth conditions v	ve need to know a	bout?			

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their PHI for the
 purpose of treatment, payment, healthcare operations, and coordination of care. As an
 example, the patient agrees to allow this chiropractic office to submit requested PHI to the
 health insurance company (or companies) provided to us by the patient for the purpose of
 payment. Be assured that this office will limit the release of all PHI to the minimum required by
 the insurance companies for payment.
- 2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- 3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- 4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
- 5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- 6. Patients have the right to file a formal complaint with our privacy official about any possible violations of the policies and procedures.
- 7. If the patient refuses to sign this consent for the purpose of treatment, payments, and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient (Print) Date	
Patient Signature Date	