AMORI
CHIROPRACTIC

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

Date_____Whom may we thank for referring you to us?_____

Patient Name_____Date of Birth_____Age_____Gender: M F

Address _____

City_____ State_____Zip_____

Cell Phone _____Home_____Preferred Phone: Home / Cell

E-mail Address_____

Would you like a reminder via TEXT or EMAIL? TEXT / EMAIL (circle one)

Emergency Contact_____Relationship_____Phone #_____

Primary Insurance Company_____Insurance ID #_____

Group #_____Insured's Name(If not self)_____

Secondary InsuranceCompany_____Insurance ID #_____

Group #_____Insured's Name (If not self)_____

Assignment and Release
I, the undersigned, assign directly to Amori Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Patient/ Responsible party agrees that in the event of non-payment, all costs of collections (not to exceed 50% of the outstanding balance) if necessary, including attorney and court costs, plus interest, shall be the full responsibility of the patient.

_____

Patient signature/Responsible party signature Date

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What is Symptom 1? (circle one)

headache neck pain
jaw pain upper back pain
low back pain shoulder pain
elbow pain hip pain
knee pain other_____

Rate the pain on a scale from 0 to 10 (circle one)

0 1 2 3 4 5 6 7 8 9 10

What percentage of time do you experience the pain? _____%

Was the pain gradual or sudden? (circle one)

What aggravates the pain? (circle)

sitting neck movement
walking movement at waist
running any movement
lifting standing
driving standing from seated position
other_____

What relieves the pain? (circle)

rest massage
ice walking
heat pain medication
stretching muscle relaxers
exercise nothing
other_____

Type of Pain (circle)

sharp dull achy burning throbbing
piercing stabbing nagging shooting
stinging other_____

When is pain worse? (circle)

morning afternoon evening night
all the time other_____

Does the pain radiate? (circle)

arm leg other_____

How long have you been experiencing this symptom?

_____

What is Symptom 2?(circle one)

Headache neck pain
jaw pain upper back pain
low back pain shoulder pain
elbow pain hip pain
knee pain other_____

Rate the pain on a scale from 0 to 10 (circle one)

0 1 2 3 4 5 6 7 8 9 10

What percentage of time do you experience the pain? _____%

Was the pain gradual or sudden? (circle one)

What aggravates the pain? (circle)

sitting neck movement
walking movement at waist
running any movement
lifting standing
driving standing from seated position
other_____

What relieves the pain? (circle)

rest massage
ice walking
heat pain medication
stretching muscle relaxers
exercise nothing
other_____

Type of Pain (circle)

sharp dull achy burning throbbing
piercing stabbing nagging shooting
stinging other_____

When is pain worse? (circle)

morning afternoon evening night
all the time other_____

Does the pain radiate? (circle)

arm leg other_____

How long have you been experiencing this symptom?

_____

Health History

Have you ever been hospitalized? If yes, what/when? _____

Have you had any major surgeries in the last 10 years? _____

Have you ever had any broken bones? If yes, what/when? _____

Have you had any recent injuries? _____

Are you currently taking any medications or supplements? If yes, what?_____
_____

_____

Do you consume soda, coffee or alcohol? _____

Do you exercise/stretch regularly? _____

When was your last physical exam? _____

Are you pregnant? _____ How far along? _____

Family History

Please indicate if any of the following conditions run in your family:

☐ 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 health conditions we need to know about? _____

_____

_____

_____

_____

_____

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.

1. 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