Dr. Anthony A. Gross, DC, CCSP
Dr. David M. Merchant, DC
(480) 820-0999

Patient Information

Today's Date:_____

Last Name:_____ Jr. Sr. III **First Name**:_____ **Middle Initial**:_____

How were you referred to our office?;_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Social Security #_____ Date of Birth_____ Date of Injury/Onset_____

Marital Status: S M W D Spouse's Name_____ Number of Children_____

Email:_____ May we email you on occasion regarding occasional promotions at our office? Circle one: Y / N - we never distribute personal info to outside parties for marketing purposes

Employer: _____Occupation:_____

Primary Physician: _____ Phone: _____

Primary Insured:_____ Relationship_____

SS# of Primary Insured_____ Primary Date of Birth_____

Insurance Company:_____ Policy #_____Group #_____

Employer:_____ Emergency Contact _____Phone_____

Financial Agreement for Personal Injury Claims

Welcome to Coyote Chiropractic. We will file your claims to the assigned insurance company on your behalf. In injury cases overseen by an attorney, the treatment charges will be presented to the attorney as needed. Please be advised our office **does not** guarantee that the insurance company and/or the assigned attorney assume responsibility for the patient's charges at Coyote Chiropractic. In the event your claim is denied, the undersigned acknowledges FULL FINANCIAL RESPONSIBILITY for all charges incurred during your (or your dependent's) care at Coyote Chiropractic. **In the event your account is submitted to collections, you will be responsible for any associated fees and charges.**

The undersigned will be responsible for a $35.00 returned check fee.

MISSED APPOINTMENT POLICY/CANCELLATION POLICY

Your appointment times are carefully scheduled to deliver efficient care to all of our patients. Missed appointments may deny other patients from receiving care during that time slot; **therefore, we have instituted a $25.00 "missed appointment" fee should you not notify us of a schedule conflict within 24 hours of your next appointment.**

By signing below, you affirm that you accept and understand these policies.

_____ _____

Responsible Party's Signature **Date**

Automobile Accident Description

Date of accident:_____ Time of accident:_____ am pm

Name of street where accident happened (be specific):_____
_____
Name of City:_____

Approximate address near accident site:_____

Name of closest cross street:_____

Did accident happen near a freeway? yes_____ no_____ What freeway?_____

What County did accident happen in?_____

What police department did the accident investigation?_____

Do you have a copy of the police report? yes_____ no_____(we require a copy of the police report for your file – please provide a copy as soon as possible)

Name of other Driver: _____

Did other driver's insurance company accept liability? yes_____ no_____

Your Automobile insurance;
Insurance Company name_____
Address:_____
City:_____State:_____
Phone:_____
Claim Number:_____Policy Number:_____
Insured Name:_____
Adjuster's Name:_____

Other Driver's Insurance:
Insurance Company name_____
Address:_____
City:_____State:_____
Phone:_____
Claim Number:_____Policy Number:_____
Insured Name:_____
Adjuster's Name:_____

Have you retained an attorney? yes_____ no_____
Attorney Name:_____ Phone:_____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type
❑Car ❑Station Wagon
❑Van ❑Pickup Truck
❑Large Truck ❑Bus
Other_____

2. Your position in vehicle
❑Driver ❑Front Passenger
❑Left Rear Passenger
❑Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?
❑Stopped at intersection ❑Stopped in traffic ❑Stopped at light
❑Making a right turn ❑Making a left turn ❑Parking
❑Proceeding along ❑Slowing down ❑Accelerating
Other_____

4. Time/Speed/Damage
Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑Mild ❑Moderate
❑Totaled

5. Details of Accident
Visibility at time of accident
❑Poor ❑Fair ❑Good

Who hit who/what?
❑You hit other vehicle
❑Other vehicle hit you
You hit...(object)
_____

6. Road conditions
Road conditions at time of accident
❑Icy ❑Wet ❑Sandy ❑Dark ❑Clean and dry

Point of impact
❑Head-On ❑Left Front ❑Right Front
❑Read-End ❑Left Rear ❑Right Rear

7. Body Position, etc.

Did you see the accident coming:? **Yes❑ ❑No**
Were you braced for the impact? **Yes❑ ❑No**
Did you have a seat belt on? **Yes❑ ❑No**
Was your shoulder harness on? **Yes❑ ❑No**
Did driver side airbag deploy? **Yes❑ ❑No**
Did passenger side airbag deploy? **Yes❑ ❑No**
Side airbags? **Yes❑ ❑No**

Does your vehicle have headrests? Yes❑❑No
What was the position of your headrest at the time of the impact?
❑Even with top of head ❑Even with bottom of head ❑Middle of neck
What was the direction of your head at the time of the impact?
❑Facing straight forward ❑Turned to the right ❑Turned to the left

8. During the accident:
Did your body strike inside of your vehicle? **Yes❑❑No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑❑No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑Mild ❑Moderate ❑Totaled
Did police show up at the scene? **Yes❑ ❑No**
Was an accident report filled out? **Yes❑ ❑No**

9. After the accident:
Check off your symptoms following the accident:

❑Headache	❑Dizziness	❑Mid back pain	❑Cold hands
❑Neck pain	❑Nausea	❑Low back pain	❑Cold feet
❑Neck stiffness	❑Confusion	❑Nervousness	❑Diarrhea
❑Fainting	❑Fatigue	❑Loss of taste	❑Depression
❑Ringing in ears	❑Tension	❑Toe numbness	❑Anxious
❑Loss of smell	❑Irritability	❑Constipation	❑Chest Pain

❑Pain behind eyes ❑Shortness of breath ❑Sleeping problems
Others:_____

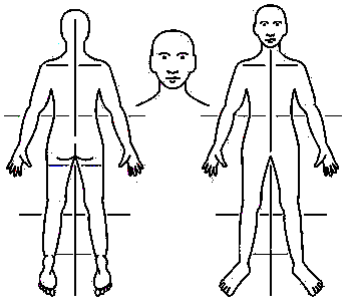
10. Emergency Room?
Where did you go after the accident?
❑Home ❑Work ❑Hospital ER ❑Private Doctor
How did you get there?
❑Self ❑Somebody else ❑Ambulance. ❑Police
X-rays done? Yes❑❑No Lab work? Yes❑❑No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ❑Cervical Collar ❑Ice **Other:**_____
Medications:_____
Follow-up instructions: _____
_____

11. Treatment History:
Fill in other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑❑No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No**
Last visit date: ____/____/____

Coyote Chiropractic & Wellness Centers, PC
Patient Health Questionnaire

Patient Name _____

Please mark the areas of complaint



Please describe your current problem _____

_____

Is your current problem the result of: Auto Accident? □Yes □No

Work Accident? □Yes □No Slip & Fall? □Yes □No

How did your problem begin?_____

Date Problem began _____

Other doctors seen for this condition _____

List other treatments or tests you've had for this condition _____

Have you been treated for any other health condition by a physician in the last year? □Yes □No If yes, please explain:

_____

How often are your symptoms present? □ Constantly □ Frequently □ Occasionally □ Intermittently

Describe your current pain/symptoms: □ Sharp/Stabbing □ Burning □ Throbbing □ Shooting □ Tingling □Gripping
□ Dull □ Numbness □Soreness □Aches □ Weakness □ Other _____

Since it began, is your problem: □ Improving □ Getting Worse □ No Change

What makes the problem better? □ Nothing □ Lying Down □ Standing □ Walking □ Sitting □ Movement
□ Exercise □ Inactivity/Rest □ Other _____

What makes the problem worse? □ Nothing □ Lying Down □ Standing □ Walking □ Sitting □ Movement
□ Exercise □ Inactivity/Rest □ Other _____

Can you perform your daily home activities? □ Yes □ Only with help □ Not at all

Do you exercise? □ Yes, often □ Yes, occasionally □ Not at all

Describe your job requirements: □ Mainly Sitting □ Light Labor □ Heavy Labor □ Other_____

Can you perform your daily work activities? □ Yes, all activities □ Only some □ Not at all

Describe your stress level: □ None to mild □ Moderate □ High

Pediatric Records: (under 17) Are your immunizations up to date? □ Yes □ No
Please provide (to the best of your ability) complete immunization record.

Please list all allergies including allergies to medications: _____

List all medications you are presently taking (including vitamins & supplements) _____

_____

List any surgeries, fractures, serious illnesses or hospitalizations _____

_____

□ Coffee/Caffeine/Energy Drinks/Day____wk____
□ Smoking - Packs/Day_____
□ Alcohol Use – Drinks/day____ week
□ Drug Use_____

Coyote Chiropractic & Wellness Centers, PC
Patient Health Questionnaire

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- □ Angina
- □ Anorexia
- □ Aortic Aneurysm
- □ Arthritis
- □ Asthma
- □ Bladder Infection
- □ Blood Disorder
- □ Breast Lump
- □ Cancer (breast, prostate etc.)
- □ Chest Pain
- □ Chronic Cough
- □ Chronic Sinusitis
- □ Colitis
- □ Convulsions
- □ Diabetes
- □ Depression
- □ Digestive Disorders
- □ Dizziness
- □ Emphysema
- □ Epilepsy
- □ Fainting
- □ Headache
- □ Heart Disease
- □ Heartburn/Indigestion
- □ Hepatitis
- □ Herniated Disk
- □ High Blood Pressure
- □ Jaw Pain
- □ Liver/Gallbladder Problems
- □ Kidney Disorders
- □ Loss of Bladder Control
- □ Nervousness
- □ Pacemaker
- □ Pain - Neck
- □ Pain - Mid Back
- □ Pain - Low Back
- □ Pain - Arm/Elbow
- □ Pain - Hand
- □ Pain - Wrist
- □ Pain - Shoulder
- □ Pain - Ankle or Foot
- □ Pain - Leg
- □ Pain - Knee
- □ PMS/PMDD
- □ Prostate Problems
- □ Rapid Heartbeat
- □ Rheumatic Fever
- □ Pregnancies
- □ Scoliosis
- □ Stroke
- □ Swelling, Stiffness of Joints
- □ Tinnitus (Ear Noises)
- □ Tuberculosis
- □ Ulcer
- □ Vision Disturbances
- □ Venereal Disease
- □ Other _____

Height: _____ feet _____ inches

Weight: _____ pounds

Dominant Hand: R / L (please circle)

Family Health History:

If a family member has had any of the following, please mark the appropriate box:

□ Cancer □ Diabetes □ Heart Problems □ High Blood Pressure □ Chronic Headaches
□ Epilepsy □ Thyroid □ Lupus □ Lung Problems □ Chronic Back Problems
□ Rheumatoid Arthritis □ Alcoholism Other _____

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received or reviewed a copy of this notice (available in the front reception area).

_____ _____

Patient name printed Authorized Provider Representative

_____ _____

Patient Signature Authorized Provider Signature

_____ _____

Personal representative Printed Date

_____

Date

_____

Description of personal representative's authority to act for the patient.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of the date listed below as signed by the patient. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____
Patient name printed	Authorized Provider Representative
_____	_____
Patient Signature	Authorized Provider Signature
_____	_____
Personal representative Printed	Date
_____	
Date	

_____

Description of personal representative's authority to act for the patient.

PATIENT CONSENT TO TREATMENT

Please read prior to signing. Please ask any questions if there is anything this is unclear.

The nature of the chiropractic adjustment
A primary treatment we use as a Doctor of Chiropractic is spinal manipulation therapy. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" and you may feel a sense of movement.

Analysis/Examination/Treatment
As a part of the analysis, examination, and treatment, you are consenting to procedures that we may recommend and/or discuss with you.

The material risks are inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to neck arteries leading to or contributing to serious complications including stroke. It is not uncommon to feel some stiffness and soreness following the first few days of treatment. We will make a reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.
Fractures from chiropractic treatment are rare and generally result from some underlying weakness of the bone which we screen for during the taking of your history, exam and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally describes as rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
-Self-administered, over-the-counter analgesics and rest
-Medical care and prescription drugs such as anti-inflammatory, muscle relaxant and pain-killers
-Hospitalization and/or Surgery

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.
I have read { } or have had read to me { } the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Coyote Chiropractic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I here give my consent to that treatment.

_____ _____
Patient's Name **Doctor Name**

_____ _____
Patient's Signature **Guardian Signature if Patient is a minor**

_____
Date