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

Patient Information

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

If any signer is entitled to benefits under any insurance policy, the benefits are hereby assigned to Coyote Chiropractic for application on the patient's bill; however, **IT IS UNDERSTOOD THAT THE UNDERSIGNED AND THE PATIENT ARE PRIMARILY LIABLE FOR PAYMENT OF THE PATIENT'S BILL (including any deductible).** It is intended by this provision to allow Coyote Chiropractic to bill and receive payments directly from the above insurance company without giving up our right to bill and collect from the undersigned all unpaid services rendered by Coyote Chiropractic. **Our office will not enter a dispute with your insurance company over any claims.** Please be advised that verification of insurance coverage is not a guarantee of benefit payments. **In the event your account is submitted to collections, you will be responsible for all associated charges and fees.**

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.**

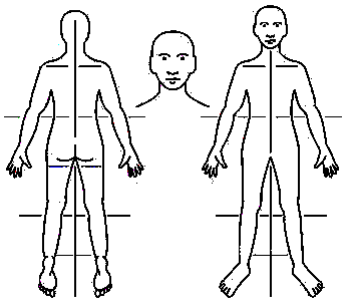
By signing below, you affirm that you accept and understand these policies.

_____ _____

Responsible Party's Signature **Date**

Coyote Chiropractic & Wellness Centers, PC
Patient Health Questionnaire

Please mark the areas of complaint



Patient Name _____

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