New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____

Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (work) _____ (home) _____ Referred By _____

Age _____ Birth date _____ Social Security # _____ Number of children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's name _____ Spouse's Occupation _____

Spouse's employer _____ Spouse's health status _____

Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* ☐ Work ☐ Other ☐

Please describe _____

_____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? ☐ No ☐ Yes If yes, when? _____

List other practioners seen for this injury/condition _____

Have you ever been under chiropractic care? ☐ No ☐ Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? ☐ No ☐ Yes Name of company _____

** If an auto accident please provide:*

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Seasonal / Out of State Patient

Please provide the following information:

Permanent Address: (Other than your Arizona address)

Address: _____

City: _____

State: _____

Zip: _____

Phone #: _____

Superstition Chiropractic Center
1946 S. Signal Butte Rd Ste. A105
Mesa, AZ. 85209
Phone: 480-857-2098
Fax: 480-983-7097

Authorization to Release/Receive Records

Date: _____

Patient's Name: _____ Date of Birth: _____

I give authorization to:

Superstition Chiropractic Center
1946 S. Signal Butte Rd Ste. A105
Mesa, AZ. 85209

To release the following information (please circle)

X-rays

Any information regarding diagnosis,
recent treatment & examinations without x-rays

Any information regarding diagnosis,
recent treatment & examinations with x-rays

Other: _____

To

Premier Radiology
4275 E. La Paloma Dr.
Tucson, AZ 85718

_____ Date: _____
Patient (Parent/Legal Guardian if Minor) Signature

(12/13) Dr. Initials _____

Designation of Authorization Representative

Superstition Chiropractic Center

5341 S. Superstition Mountain Drive # D101
Gold Canyon, AZ. 85118

I, _____, so hereby designate the staff of
Patient Name (please print)
Superstition Chiropractic Center including Dr. Ryan Wade D.C. and Dr. Cassie Bradley D.C. hereafter referred to as doctor's, to the full extent permissible under the Employee Retirement Income Security Act of 1974 (ERISA) and as provided in 29DFR2560-503-1(b) 4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above doctor's. These rights include the right to act on my behalf with respect to initial determination of claims, to pursue appeals of benefit determination under the plan, obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expenses(s) as the result of the services I received from the doctors listed above.

_____
Date

_____
Patient Printed Name

_____
Patient (Parent/Legal Guardian if Minor) Signature

Superstition Chiropractic Center
5341 S. Superstition Mountain Drive #D101
Gold Canyon, AZ. 85218
Phone: 480-983-2249
Fax: 480-983-1541

Patient and Doctor Agreement

As a patient of Superstition Chiropractic Center, I understand that the treating doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis, or referral.

I authorize the doctor to treat my condition as the doctor deems appropriate through adjusting my spinal column. I also understand and agree that the amount paid to Superstition Chiropractic Center for x-rays is for the examination only, and the **x-ray negatives will remain the property of this office.** I further understand that they may be seen by me at any time while I am a patient of this office with proper notification. X-rays negatives that are requested by the patient may be picked up only by the patient but must be returned within 30 days.

I agree that I am responsible for all bills incurred at this office unless a financial agreement with Superstition Chiropractic Center has been signed. It is further understood and agreed that health insurance policies are an arrangement between the insurance carrier and me. I understand that the doctor's office will bill my insurance carrier and any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that I am financially responsible for any unpaid services that are a result of changes to my insurance. I also understand that if I suspend or terminate care, any unpaid fees for professional services rendered will be immediately due and payable.

Patient Name: _____

_____ _____
Patient (Parent/Legal Guardian if Minor) Signature Date

Privacy Practices Acknowledgement

Superstition Chiropractic Center

5341 S. Superstition Mountain Rd. #D101
Gold Canyon, AZ. 85218

Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name: _____Birth date:_____
(Please Print)

If you want anyone else to have permission to receive your medical information from this office, Please print name and relationship on lines below.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

None

_____ _____
Patient (Parent/Legal Guardian if Minor) Signature Date

Superstition Chiropractic Center
5341 S. Superstition Mountain Drive # D101
Gold Canyon, AZ. 85118

Doctor Patient Relationship in Chiropractic

Chiropractic

It is important to recognize the difference between chiropractic and medicine. Either can be important to your health but for entirely different reasons. Chiropractors seek to restore health through natural means and without the use of medicine or surgery. Although a medical diagnosis may be of great importance to a patient, such diagnosis does not necessarily assist the chiropractor in his efforts. The Chiropractor's purpose is to restore health through the natural flow of energy in the nervous system. This gives the body maximum opportunity to heal itself. The success of the chiropractic procedures often depended upon underlying causes and conditions. It is important to understand what to expect from chiropractic and medical services in order that you, the patient can determine whether either or both may be if benefit to you.

Diagnosis

Although Chiropractors are experts in chiropractic analysis, they are not specialists in the field of diagnosis. Internists are medical specialists who are highly qualified to diagnosis. Every chiropractic patient should be mindful if his own symptoms and should secure medical opinion if he has any concern as to the nature if his illness or injury. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you should take the initiative if in doubt.

Chiropractic Adjustments

The patient, in coming to the Chiropractor, gives the Chiropractor permission and authority to adjust the patient in accordance with the chiropractic analysis. The chiropractic adjustment is usually beneficial, and seldom causes any problem. In rare cases, underlying physical defects, deformities, or pathology may render the patient susceptible to injury. The Chiropractor, of course, will not give a chiropractic adjustment if he is aware that such condition exists. Again, it is the responsibility of the patient to make it known to learn through medical procedures whether he is suffering from latent pathological defects, illness or deformity which would otherwise not come to the attention of the Chiropractor. The patient should not look to the Doctor of Chiropractic for in-depth diagnostic procedures. The Doctor of Chiropractic provides a specialized health service and does not and should not become involved in the patients medical regime. A patient should never ask or accept advice from a Chiropractor concerning the taking of prescriptive medicines. The Doctor of Chiropractic is not licensed in medical practices.

Result

The purpose of chiropractic services is to promote natural health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes the result is phenomenal. In some cases, there is a more gradual but quite satisfactory response. Occasionally, the results are mediocre or dismal. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic care. In turn, we must admit that conditions, which do not respond with chiropractic care, may come under control or be cured through medical science. The fact is the sciences of chiropractic and medicine may never be so exact as to provide definite answers to many problems. Both have made great strides in alleviating pain and controlling disease.

Questions

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

Acknowledgement

I have read the foregoing and understand it.

Patient Name:_____

Signed this _____ day of _____ 20___.

_____

Patient (Parent/Legal Guardian if Minor) Signature

Cancellation Policy

Superstition Chiropractic Center

5341 S. Superstition Mountain Drive # D101
Gold Canyon, AZ. 85118

Patient Name:_____

A fee of $35.00 will be charged to your account and will be payable upon next visit for appointments that are missed or for non-notification of change at least 1 hour before scheduled time.

Patient (Parent/Legal Guardian if Minor) Signature **Date**