PATIENT INTRODUCTION

Name: _____ **Date:** _____

Preferred Name: _____ **Email:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____

Home Phone: _____ **Mobile #:** _____

Gender: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Other

Date of Birth: _____ **Social Security #:** _____

Referred By: ☐ *Family OR Friend:* _____ ☐ *Insurance* ☐ *Doctor* ☐ *Internet* ☐ *Other Source*

EMERGENCY CONTACT INFORMATION:

Name: _____ **Home:** _____ **Mobile:** _____

Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

Primary Care Physician: _____ **Doctor's Phone:** _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay *(Cash)* ☐ Personal Injury/Auto ☐ Other:_____

PRIOR MEDICAL HISTORY: Please check all of the following that apply to you.

- ☐ Stroke *Date:*_____
- ☐ Dizziness / Fainting
- ☐ Numbness in Groin / Buttocks
- ☐ Epilepsy / Seizures
- ☐ Visual Disturbances
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Corticosteroid Use (Cortisone, prednisone, etc.)
- ☐ Osteoporosis
- ☐ Recent Fall *Date:*_____
- ☐ Recent Fever
- ☐ Currently Pregnant, # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain at Night
- ☐ Cancer / Tumor (explain)_____
- ☐ **Medications:**_____
- ☐ **Surgeries:**_____
- ☐ **Other Health Problems (explain)**_____

PLEASE FEEL FREE TO USE REVERSE SIDE OF PAPER – Copies of Medications/Surgeries Welcome

FAMILY HISTORY

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Problems/ Stroke
- ☐ Rheumatoid Arthritis

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED

HISTORY OF CURRENT CONDITION

*VAS*_____

NAME:_____ **DATE:**_____

Are you currently pregnant? Yes / No If Yes, How far along: _____

Is this a flare up of a previous condition?: Yes / No

PLEASE LIST ALL AREAS OF CONCERN YOU WOULD LIKE ADDRESSED:

_____

When did your condition/flare up start?: _____ What caused it: _____

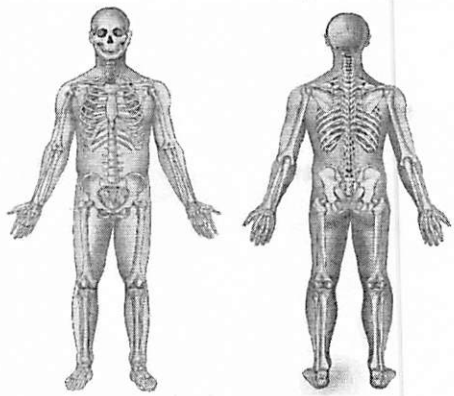
Does the pain radiate to additional area of your body? Yes / No If Yes Where:_____

Have there been any new traumas? (auto accidents, falls, etc.) Date of Injury: _____/_____/_____

New or Recent surgeries? Yes / No If yes, what surgery and when?:_____

Is the discomfort:: Aching / Dull / Burning / Sharp / Stabbing / Stiff / Numb-tingling / Other: _____

Mark areas of complaint



Please Circle Pain Intensity

1-2: Mild Pain

2-4: Mild - Moderate Pain

4-6: Moderate Pain

6-8: Moderate - Severe Pain

8-9: Severe Pain

Is your complaint getting : Better / Same / Worse **from when it started most recently?**

How often do you feel the discomfort? 16+ hours / 10-16 hours / 7-10 hours / 3-7 hours / 1-3 hours

What makes it feel better: Ice / Heat / Rest / Massage / Stretching / OTC or RX meds / Chiropractic / Other:

_____

Have you seen another provider for this complaint: No One / Chiro / MD / PT / Massage / ER / Other

Diagnostic Tests: None / X-rays / MRI / CT / Other: _____ Where & When _____

What aggravates your pain? (please select any that apply)

	Immediately	5 min.	10 min.	Other
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Drive Car	☐	☐	☐	☐
Cooking	☐	☐	☐	☐
Lie Down	☐	☐	☐	☐

	Immediately	5 min.	10 min.	Other
Sit	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Reach overhead	☐	☐	☐	☐
Use computer	☐	☐	☐	☐
_____ ***(other)***	☐	☐	☐	☐

Patient Signature: _____ **Date of birth:** _____

SURPRISE CHIROPRACTIC

Louis V. Verloop, D.C

Derek M. Legg, D.C., M.P.H.

14515 W Grand Ave suite #C128, Surprise, AZ 85374

P : 623-544-9111 F : 623-544-9333 E: Surprisechiropractic@gmail.com

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and that the fees for the professional services rendered to me will be immediately due and payable.

ASSIGNMENT OF BENEFITS

I hereby authorize Surprise Chiropractic, LLC to release any information necessary to process this claim and assign ALL BENEFITS payable directly to Surprise Chiropractic, LLC. I waive the Statute of Limitations regarding my chiropractic physician's right to recover. I understand that whatever amount is not collected from insurance proceeds, (whether it be all or part, when insurance benefits exhaust or are denied for whatever reason), I am personally responsible. If collection or legal action should become necessary in payment of services rendered by Surprise Chiropractic, LLC, I understand that I will be personally responsible for all fees incurred by Surprise Chiropractic, LLC, made to collect that payment due.

CONSENT TO RELEASE OF INFORMATION

I hereby authorize and release the chiropractic physician and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, workers compensation carriers, welfare funds, or the patient's employer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information (PHI). The Notice of Patient Privacy Practices describes the uses and disclosures of my PHI that will occur in payment of my bills and coordination of care within our office, as well as, management of health care and related services within Surprise Chiropractic. The Notice of Privacy Practices describes my rights and the duties of Surprise Chiropractic with respect of my PHI. Upon request the Notice of Privacy Practices will be provided at the front desk. Surprise Chiropractic reserves the right to change privacy practices. I may retain a revised copy at any time upon request.

By initialing the above and signing this document, I acknowledge and understand my rights as a patient.

Printed Name: _____ **DOB:**_____

Patient Signature: _____ **DATE:**_____

AUTHORIZATION (HIPAA RELEASE)

I _____, give authorization to the following individuals listed below to:

- Communicate with Surprise Chiropractic by way of text, emails, in person, or phone on my behalf to discuss my schedule, reschedule, or cancel appointments. **( ) YES ( ) NO**
- Communicate in regard to billing and results pertaining to my care with Surprise Chiropractic. **( ) YES ( ) NO**

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name: _____Relationship: _____

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INFORMED CONSENT TO CHIROPRACTIC & ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and acupuncture procedures including various modes of therapeutic procedures, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services will be performed by a Physician of Chiropractic named here Dr. Louis V. Verloop and/or Dr. Derek M. Legg now or in the future at this office. I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with clinic personnel. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the chiropractic physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the chiropractic physician to exercise judgment during the course of the procedure which the chiropractic physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractic physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the *Patient*:

_____ _____

Print Name of Patient *Signature of Patient*

To be completed by the *Patient's Representative*, if patient is a minor or is physically or mentally incapacitated:

_____

Print Name of Patient

_____ _____

Print Name of Representative *Signature of Representative*

Form to be maintained in the patient's health record.