DeMent Family Chiropractic
Improving your family's health naturally
6520 E. Carondelet Dr., Tucson, AZ 85710 (520) 298-4999 Dr. Scott DeMent, D.C. and Dr. Melody DeMent, D.C.

FOR PATIENTS WHO HAVEN'T BEEN SEEN IN PAST 6 MONTHS OR WHO HAVE A NEW CONDITION

First Name_____ **Last Name** _____

Date of Birth _____/_____/_____

Address _____

City _____ **Zip Code** _____ **Primary Phone** _____

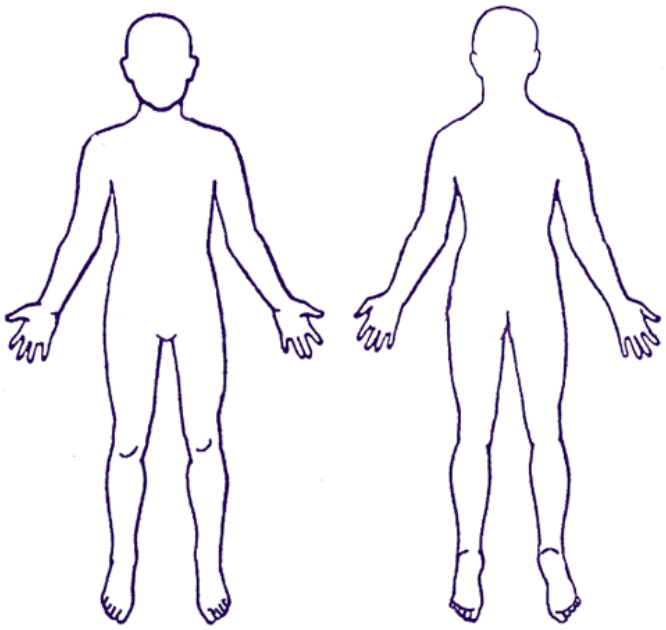
Secondary Phone _____ **Mobile Phone** _____**Can we text you? Yes/No**

Home email _____ **Work Email**_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Insurance _____ *(Please show your card to the front desk staff.)*

Front **Back**



Place an "X" on the drawings to the left wherever you have pain.

1. Describe each of your symptom(s):

a.Symptom/location:_____

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse)

How much of the day do you experience pain?: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

When did this start? _____

b.Symptom/location:_____

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse)

How much of the day do you experience pain?: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

_____

Staff Initials: _____ Scott DeMent, D.C. _____ Melody DeMent, D.C. _____

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When did this start? _____

Patient Name: _____

c.Symptom/location:_____

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse)

How much of the day do you experience pain?: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

When did this start? _____

d. Symptom/location:_____

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse)

How much of the day do you experience pain?: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

When did this start? _____

2a. What other doctors have you seen for the problem(s)? _____

_____

2b. Did their treatment help? _____

_____

3. Is this due to an accident? Car_____ Work_____ Other_____ None_____

4. Do you find it hard to.....?: (check those that apply)

Walk _____ Ride in a Car _____ Work _____ Bend____ Stand_____ Sit _____ Lift _____ Other _____

5. Have there been any changes to your medical history since you last visited this office? Is there any other condition you have that we have not discussed that you would like to discuss at this time? If yes, please explain (e.g. Headaches/ Bowel/ Stomach/ Urinary/ Breathing/Change of Medications)_____

_____

6. Are you here for: ☐Overall Health ☐Pain relief ☐Crisis Care

PROFESSIONAL COURTESY: By my signature below, I request and authorize DeMent Family Chiropractic to provide my medical doctor with a report for my medical record. Please send to:

Name of Medical Doctor :_____ Office Name: _____

Office Address: _____ Telephone : (_____) _____ - _____

Patient Name (Please Print) : _____ Date: _____/_____/_____

Patient Signature:_____

AUTHORIZATION TO RELEASE INFORMATION: DeMent Family Chiropractic is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, personal physicians, other healthcare providers, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by DeMent Family Chiropractic. This also includes its designated associates and assistants. I also hereby release DeMent Family Chiropractic from any consequence and/or liability concerning the same.

_____

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Patient Name: _____

HIPAA: I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand that this office wants me to understand how my Patient Health Information is going to be used in this office and my rights concerning those records. If I would like to have a more detailed account of their policies and procedures concerning the privacy of my Patient Health Information, I understand that I can read or request a copy of the HIPAA NOTICE that is available to me at the front desk or on their website (www.tucsonchiropractors.com) before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

PAYMENT: I understand and agree that I am responsible for all costs of care, regardless of insurance coverage. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I also understand that consultations are complementary but exams, x-rays and treatment procedures must be paid for on the day that the services are rendered unless a written agreement has been made prior to those services being rendered.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than sixty (60) days overdue and I have not made a financial agreement with the office, I will incur interest on my past due balance of eighteen percent (18%) per annum. I further acknowledge and agree that DeMent Family Chiropractic shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due accounts with DeMent Family Chiropractic.

CONSENT TO CARE FOR A MINOR: I hereby authorize DeMent Chiropractic to administer care as deemed necessary to: _____

PATIENT RECORDS: I understand that I may request my records and x-rays from DeMent Family Chiropractic and that it can take up to 10 business days for the records to become available.

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be detrimental to my health. It is my responsibility to inform DeMent Family Chiropractic of any changes in my health status. By my signature below, I understand and agree to the above policies, procedures, authorizations and agreements.

_____	_____	_____/_____/_____
Patient Name (Please Print)	Patient Signature	Date
_____	_____	_____/_____/_____
Guardian Name (Please Print)	Guardian Signature	Date

_____

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