DeMent Family Chiropractic
Improving your family's health naturally

6520 E. Carondelet Drive, Tucson, AZ 85710 (520) 298-4999
Dr. Scott DeMent, D.C. and Dr. Melody DeMent, D.C.

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____**Mobile Phone** _____
Home Email _____ **Work Email**_____
By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** ____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ Other:_____ ❑ I choose not to specify

Verification Question *(Choose only one question. Then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Whom may we thank for referring you? _____
or did you hear about us from?:❑Website/Internet ❑Newspaper ❑Event_____ ❑Window display
Emergency Contact: _____ Phone: (_____) _____ - _____
Emergency contact is your: ❑Spouse/partner ❑Parent ❑Other: _____
****

Insurance: Please check any and all insurance coverage that may be applicable in this case**:**
❑ Major Medical ❑ Worker's Compensation ❑ Medicaid ❑ Medicare ❑ Auto Accident
❑ Medical Savings Account & Flex Plans ❑ Other
Name of Primary Insurance Company: Name of Secondary Insurance Company (if any):

_____ _____
Policy Holder's Name (other than self) Policy Holder's Date of Birth
_____ _____/_____/_____

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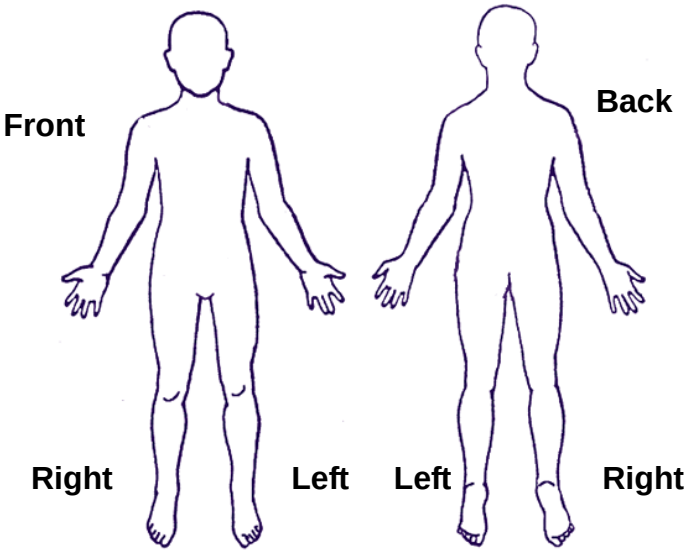
Patient Name: _____

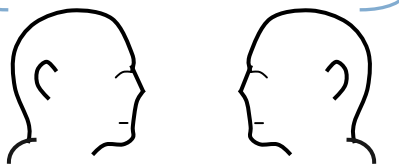
Tell Us Why You are Here

What is the primary reason for your visit? _____
Is this due to a: ❑Automobile accident ❑Work-related injury ❑Personal injury case ❑N/A
When did your pain/symptoms begin (include date if possible)? _____
Have you had an X-ray or CT scan or MRI of your low back or neck in the past 28 days? ❑ Yes ❑ No
Where?: _____
WOMEN ONLY: To your knowledge are you pregnant? ❑No ❑Yes Due date: _____/_____/_____

SUBJECTIVE PAIN ASSESSMENT



RATE YOUR PAIN: Place an "X" on the drawings wherever you have pain.



PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

Are any of the following activities difficult to carry out due to your present condition?:

❑ Sitting	❑ Standing	❑ Walking	❑ Bending	❑ Stooping	❑ Lifting
❑ Sleeping	❑ Sneezing/Coughing	❑ Straining	❑ Reaching	❑Twisting	
❑ Looking Up	❑ Looking Down	❑ Movement	❑ Rest	❑ Lying on Back	❑Driving
❑ Computer work	❑ Scooping	❑ House chores	❑ Exercise	❑Lying face down	❑ Walking Stairs

❑ Other_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

List current illnesses with any medications & vitamins, including frequency and dosage if known. If there are no current medications, check here: ❑ example: heart disease/aspirin 1x/day

1) _____ **5)** _____
2) _____ **6)** _____
3) _____ **7)** _____
4) _____ **8)** _____

List surgeries/hospitalizations.

1) _____ **3)** _____
2) _____ **4)** _____

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Patient Name: _____

List family history of cancer, diabetes, heart disease/high blood pressure/stroke:
example: father/heart disease

1) _____ **5)** _____
2) _____ **6)** _____
3) _____ **7)** _____
4) _____ **8)**

Review of Systems

Please mark whether you had in the **PAST** or **NOW** have any of the following conditions/illnesses:

Past	Now	General	Past	Now	General Gastro-Intestinal
		Fatigue or Weakness			Abdominal Pain
		Night Sweats			Indigestion / Upset Stomach/Excess Gas
		Unexpected Weight Change			Heartburn
		Jaw Pain/TMJ			Constipation
		Sleeping Problems			Diarrhea
		Loss of Balance			Nausea or Vomiting
		Dizziness/Vertigo/Fainting	**Past**	**Now**	**Genito-Urinary**
		Headaches			Bed Wetting
		Seizures			Urinary Pain or Frequency
		Loss of Memory			Kidney or Bladder Trouble
		Excessive Thirst			Blood in Urine or Stool
		Thyroid Trouble			Menstrual Problems or Pain
		Anxiety or Nervousness			Prostate Trouble
		Mood Swings or Irritability			Erectile Dysfunction
		Mental or Emotional Difficulty			Fertility Problems
		Depression	**Past**	**Now**	**Musculoskeletal**
Past	**Now**	**Eyes, Ears, Nose & Throat**			Arthritis
		Vision Trouble			Bone Fracture
		Hearing Trouble/Ringing in Ears			Dislocated Joints
		Ear Infections	**Past**	**Now**	**General Cardio-Vascular**
		Loss of Smell			Chest Pain or Pressure
		Loss of Taste			Heart Trouble/Stroke/Aneurysm/BloodClot
		Difficulty Swallowing			High Blood Pressure/Low Blood Pressure
		Difficulty Speaking			Cold Hands or Feet
		Sinus Trouble			Pacemaker
Past	**Now**	**Skin**	**Past**	**Now**	**Other Health Conditions**
		Skin Problems			Autoimmune Disease Type: _____
Past	**Now**	**Respiratory**			Cancer Type: _____
		Asthma			Diabetes/Hypoglycemia
		Wheezing			Fibromyalgia
		Chronic Cough			Multiple Sclerosis
		Shortness of Breath			Tuberculosis
					Other: _____

Occupation

Job description: _____
How often does your job involve lifting? ❑Never ❑Occasionally ❑Frequently ❑Constantly
Physical stress level: ❑Low ❑Medium ❑High

Recreation

List the recreational activities that you like to do: _____

How would you rate your overall health? (awful) 0 1 2 3 4 5 6 7 8 9 10 (amazing)
Is there anything else you would like us to know? ❑No ❑Yes: _____
_____
Is there any reason why you might have trouble lying face down on an examination table? If yes, why:
_____

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Patient Name: _____

Other Health Care Providers
Have you ever been to a doctor of chiropractic before? ❑No ❑ Yes How long ago? _____
Name of previous chiropractor: _____
City: _____ State: _____ Phone #: (_____) _____ - _____
List reason: _____
Do you see a medical doctor or osteopath? ❑No ❑Yes List date of last visit: _____/_____/_____
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.
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: _____
MISSED APPOINTMENTS: I understand that it is important to keep all of my scheduled appointments in order to receive the best results. However, if I absolutely must cancel an appointment, I must provide 24 hour's notice so that the time slot can be provided to another patient. I also need to reschedule that appointment. I understand that I can be charged $15 for a missed appointment that is not canceled prior to 24 hours.
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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TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and when we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment or lack of motion of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examinations, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) (Date)