DeMent Family Chiropractic
6520 E. Carondelet Dr. Tucson, AZ 85710 520-298-4999

New Patient Registration and Accident Questionnaire ❶

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

Employer/Occupation: ____________________________________
Spouse's Name:______________________________________
Spouse's Employer/Occupation: ____________________________________

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian
❑ Native Hawaiian or other Pacific Island
❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese❑ Italian ❑ Korean❑ Russian❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

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

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Patient's Name: ____ **Date:** _____/_____/_____
Verification Question *(choose only one question by circling the 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.

In case of emergency, notify______________________ **Relationship:** ______________________________
Phone (_______**)** ___________

Current Symptoms: 1.__________________ 2.__________________ 3.__________________
4.__________________ 5. __________________ 6. __________________ 7. __________________
8. __________________

When did your symptoms begin? ____

In general what makes your symptoms better? ____

In general what makes your symptoms worse? ____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): ________________________

Are your symptoms local or do they travel to another area? (If they travel, to where?) ______________________

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

____

____

Please list all medications and dosage: **Frequency** **For What Illness?**

____

____

List any allergies to medications, foods or other: ____

Are you pregnant? ☐ Yes ☐ No

First day of last menstrual cycle:_____________________________________

Do you smoke? ☐ Yes ☐ No; How much? ___________

Do you drink alcohol? ☐ Yes ☐ No; How much? ___________

Please list all serious illness and serious accidents: **Month and Year** **City, State**

____

____

____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

____

____

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Patient's Name: ____ Date: _____/_____/_____

Date of Crash/Accident: ____________________________ Hour: ___________ ☐ AM ☐ PM

Specific Location of Crash/Accident: ____

Describe in detail, in your own words, how the crash/accident happened:

____

____

____

____

AUTOMOBILE/MOTORCYCLE ONLY

In the crash/accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other?

____

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on __________________________
(Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on _____________________________
(Street/Highway)

...

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disruption*	☐ *Bruising Anywhere*	☐ Tingling in Legs	☐ Loss of Smell
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ Loss of Taste
☐ *Anxiety*	☐ Sensitivity to Light	☐ *Jaw Pain (TMJ)*	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ *Muscle Spasms*	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms:

____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: __________________ to ____________________

Where did you go after the crash/accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work

☐ Other ___________

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Patient's Name: ____ **Date:** _____/_____/_____

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?**

____

Address: ____ Date of Hospitalization: _____/_____/_____

Attending E.R. Doctor: ______________________________ Treatment Given? ______________________

Have you done any of the following since the crash/accident?

☐ Ice ☐ Medication (name) _______________ ☐ Rest

☐ Heat (any kind) ☐ Exercise ☐ Other________________

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: ____
Address: _______________________________Telephone: (_____) _____________Insured: _________________
Claim #: ______________________________Policy #: ________________________________
Claim Representative: _______________________
Telephone: (______) _______________________ Fax: (_______) ________________________
Med-Pay Benefits: ____________ Uninsured (UM) Benefits: ___________ Underinsured (UIM) Benefits: ___________
Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure
Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No
2) YOUR HEALTH INSURANCE COMPANY: ____
Address: _______________________________ Insured: ____
Date of Birth: _________________________Policy #: _______________________ SS#: _________________
Telephone: (______) _______________________ Fax: (_______) ________________________
3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _________________________________
Address: ______________________________ Claims Rep: _______________________________________
Claim #: ______________________________Policy #: _____________________Insured: _______________
Telephone: (______) _______________________ Fax: (_______) ________________________
4) ATTORNEY: ___________________________________Legal Assistant: ______________________
Address: ____
Telephone: (______) _______________________ Fax: (_______) ________________________
Patient's Name: ____ **Date:** _____/_____/_____

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: ____

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Patient's Name: ____ Date: _____/_____/_____

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's Name: ____ Date: _____/_____/_____

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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Patient's Name: ____ Date: _____/_____/_____

INFORMED CONSENT TO CHIROPRACTIC CARE with

Dr Scott DeMent, D.C. and Dr Melody DeMent, D.C.

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative therapy) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, decompression therapy, physical medicine, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, diagrammatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had the opportunity to discuss the the doctors named above and/or office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read(Or have had read to me) that above explanation of chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment, I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Print Name of Patient:____

Signature of the Patient:____DATE:_________/________/_________

Signature of Representative:____DATE:________/_______/________
(if patient is a minor or handicapped)

Witness signature:____

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PREVIOUS PROVIDERS & HEALTH HISTORY FORM

Patient's Name: ____ Date: _____/_____/_____

Understanding your health history is important to us. Please take the time and effort to fully and accurately provide us with the following information:

Current Family Care Provider:

Name	Address	Phone	Treatment Timeframe

Past Family Care Provider(s):

Name	Address	Phone	Treatment Timeframe
1.			
2.			
3.			

Other Medical Providers Seen in the Past 5 Years Pre-Dating the Accident/Collision:

Name	Address	Phone	Timeframe Reason
1.			
2.			
3.			
4.			
5.			

Other Medical Providers Seen any Time in Your Life Prior to the Accident/Collision for Conditions Similar to Those for Which You Currently Seek Treatment:

Name	Address	Phone	Timeframe Reason
1.			
2.			
3.			
4.			
5.			

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Patient's Name: ____ **Date:** _____/_____/_____

Prior Automobile Accidents with Injury:

Date	Location	Treatment	Timeframe	Areas of Injury
1.				
2.				
3.				
4.				
5.				

Prior Work Related Injuries:

Date	Location	Treatment	Timeframe	Areas of Injury
1.				
2.				
3.				
4.				
5.				

Prior Slip/Fall Injuries:

Date	Location	Treatment	Timeframe	Areas of Injury
1.				
2.				
3.				
4.				
5.				

Other Injuries of Relevance:

Date	Location	Treatment	Timeframe	Areas of Injury
1.				
2.				
3.				

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Patient: ____

Previous Injuries, Hospitalizations, Surgeries

Date	Doctor/Hospital/ Condition	Treatment	Response (+) (-) (NC)	Treatment Duration	Test(s)	Test Result

Medications/Vitamins: ____

Allergies: ____

Family History: #1.Father, #2.Mother, #3.Sister (A, B, Etc), #4.Brother (A, B, Etc.)

Cancer	Diabetes	Heart Disease	CVA
HBP	Epilepsy	TB	Other
Other	Other	Other	Other

Psycho-Social History:

Changes to Activities of Daily Living Since the Accident: ____

____

Recreational/Exercise: Type: ________________________________ Freq. ____/Wk; Duration _____ Min. / Hrs: ______________________

Social Habits (Please Circle Appropriate Responses and Fill In The Blanks)

Tobacco: _______ Pack / ___Day, Week, For ___ Yrs; Chew ______ Yrs; Pipe _____ Yrs Caffeine (Soda, Coffee, Tea) ______/ Day

Alcohol ______ Glasses Of Wine, Beer, Mixed Drink/ Day, Wk, Mo.; Sleep Interrupted? ____ X's / Night For ____ Weeks Mo Yrs

Dr. Initials: __________

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Patient: ____ Page 5

Work Routine/Duties under Duress	Able		Restricted		Unable	Comments
Sit in office chair	1	2	3	4	5	
Stand erect	1	2	3	4	5	
Climb steps / stairs	1	2	3	4	5	
Stoop to retrieve	1	2	3	4	5	
Crouch to retrieve	1	2	3	4	5	
Kneel to retrieve	1	2	3	4	5	
Reach overhead	1	2	3	4	5	
Lift; waist to shoulder height	1	2	3	4	5	
Carry object, 100 feet	1	2	3	4	5	
Push	1	2	3	4	5	
Pull	1	2	3	4	5	
Balance	1	2	3	4	5	
Crawl	1	2	3	4	5	
Reach	1	2	3	4	5	
Handle objects appropriately	1	2	3	4	5	
Finger/Hand strength/coordination	1	2	3	4	5	

REVIEW OF SYSTEMS*: Please write all numbers that apply:* ***#1****. Presently have,* ***#2****. Previously had,* ***#3****. Related to crash*

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss
___Nervousness/depression
___Neuralgia
___Numbness
___Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

Other:____

Dr. Signature: ____Date ________________________________

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