Dynamic Chiropractic Center
Dr. Patti Lehew R.N., D.C., Dr. Alanna Bernacchi D.C., F.I.A.M.A.

Initial Health Status

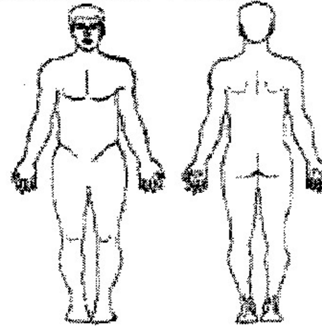
LEGAL NAME: ______________________ Date of Birth: ____________ Sex: M / F
Address: ______________________ City: ____________ State: _____ Zip: _______
Home Phone: __________________ Cell Phone: ____________________
Work Phone: __________________ Ext:____ Email: ______________________________
Social Security #: _____________ Employer: ______________ Occupation: _____________
Subscriber Name: __________________ Health Plan: ______________ DOB: __________
Subscriber ID #: _____________ Group #: __________ Spouse Name: __________________
Spouse Employer: _______________ City: __________ State: _____ Zip: ___________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

____

____



Is this? □ Work Related □ Auto Related □ N/A

DATE PROBLEM BEGAN:___________________

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How often are your symptoms present? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

Can you perform your daily activities? □ Yes □ No (Describe) ________________________

____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? □ No □ Yes **Date(s) taken:** __________

WHAT AREAS WERE TAKEN? ____

Please check all of the following that apply to you:

Past	Present	Condition	Past	Present	Condition
□	□	**History of Recent Infection**	□	□	**Osteoporosis**
□	□	**Fever**	□	□	**Trauma**
□	□	**HIV/AIDS**	□	□	**Prostate Problems**
□	□	**Diabetes**	□	□	**Frequent Urination**
□	□	**Corticosteroid Use**	□	□	**Pregnancy, # of Births**________
□	□	**Birth Control Pills**	□	□	**Abnormal Weight □ Gain□ Loss**
□	□	**High Blood Pressure**	□	□	**Epilepsy/Seizures**
□	□	**Stroke (date)**______________	□	□	**Visual**
□	□	**Dizziness/Fainting**	□	□	**Low/Mid Back Pain**
□	□	**Numbness in Groin/Buttocks**	□	□	**Neck Pain**
□	□	**Urinary Retention**	□	□	**Arthritis**
□	□	**Aortic Aneurysm**	□	□	**Alcohol Use**
□	□	**Cancer/Tumor**	□	□	**Tobacco Use**

Family History: □ **Cancer** □ **Diabetes**
□ **High Blood Pressure** □ **Cardiovascular Problems/Stroke**

Surgeries/Medications:______________________________
____
____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature__________________________ **Date:**__________ **Referred By:**____________________

9812 N. 7th St., Ste. 6, Phoenix, AZ 85020
Phone: 602-870-1876 Fax: 602-997-2291

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Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. 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, any fees for professional services rendered to me will be immediately due and payable.

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Patti Lehew, Dr. Alanna Bernacchi and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, associated with, or serving as back up for Dr. Patti Lehew or Dr. Alanna Bernacchi; including those working at the clinic or offices listed above.

I have had an opportunity to discuss with Dr. Patti Lehew, Dr. Alanna Bernacchi, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other physiotherapy procedures. I understand that results are not guaranteed.

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

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatments.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor 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; I further authorize him/her to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, not limited to, hospital or medical services companies, worker's compensation carriers, welfare funds, or the patient's employer.

Print Name:_______________________________________ Date:____________

Patient Signature:_________________________________ Date:____________

Parent's or Guardian's Signature:___________________ Date:____________

Staff Witness:____________________________________ Date:____________

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Authorization to Release Medical Information

TO:____
(NAME OF DOCTOR, HOSPITAL, CLINIC, ETC.)
PHONE #:______________________
FAX #:________________________
ADDRESS:_____________________
____

I, ___________________________, ___/___/___ request the following information:
(PATIENT'S NAME) (DOB)

□ X-rays □ History □ Records □ Diagnosis □ Treatment
□ Reports □ Billing □ Other______________________

concerning my: □ Accident □ Injury □ Illness □ Other____________

to be released to: Dynamic Chiropractic Center, Inc.
9812 N. 7th St., #6
Phoenix, AZ 85020
Phone: 602-870-1876 Fax: 602-997-2291

for the purpose of: __________________________________
(PLEASE SPECIFY)

Name:______________________________ Date:______________
(SIGNATURE)
□ Patient □ Spouse □ Parent □ Guardian

Additional Comments:_______________________________________
____
____
____

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Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Dynamic Chiropractic Center** medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Dynamic Chiropractic Center to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Dynamic Chiropractic Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_______________________________________ ____________________
Patient/Responsible Party Signature Date

_______________________________________ ____________________
Witness Date

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