



Dr. Anthony A. Gross, DC, CCSP
Dr. David M. Merchant, DC
(480) 820-0999

Patient Information

Today's Date: _____

Last Name: _____ Jr. Sr. III First Name: _____ Middle Initial: _____

How were you referred to our office?: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Social Security # _____ Date of Birth _____ Date of Injury/Onset _____

Marital Status: S M W D Spouse's Name _____ Number of Children _____

Email: _____ May we email you on occasion regarding occasional promotions at our office? Circle one: Y / N - we never distribute personal info to outside parties for marketing purposes

Employer: _____ Occupation: _____

Primary Physician: _____ Phone: _____

Primary Insured: _____ Relationship _____

SS# of Primary Insured _____ Primary Date of Birth _____

Insurance Company: _____ Policy # _____ Group # _____

Employer: _____ Emergency Contact _____ Phone _____

Financial Agreement for Personal Injury Claims

Welcome to Coyote Chiropractic. We will file your claims to the assigned insurance company on your behalf. In injury cases overseen by an attorney, the treatment charges will be presented to the attorney as needed. Please be advised our office **does not** guarantee that the insurance company and/or the assigned attorney assume responsibility for the patient's charges at Coyote Chiropractic. In the event your claim is denied, the undersigned acknowledges FULL FINANCIAL RESPONSIBILITY for all charges incurred during your (or your dependent's) care at Coyote Chiropractic. **In the event your account is submitted to collections, you will be responsible for any associated fees and charges.**

The undersigned will be responsible for a \$35.00 returned check fee.

MISSED APPOINTMENT POLICY/CANCELLATION POLICY

Your appointment times are carefully scheduled to deliver efficient care to all of our patients. Missed appointments may deny other patients from receiving care during that time slot; **therefore, we have instituted a \$25.00 "missed appointment" fee should you not notify us of a schedule conflict within 24 hours of your next appointment.**

By signing below, you affirm that you accept and understand these policies.

Responsible Party's Signature

Date

Automobile Accident Description

Date of accident: _____ Time of accident: _____ am pm

Name of street where accident happened (be specific): _____

Name of City: _____

Approximate address near accident site: _____

Name of closest cross street: _____

Did accident happen near a freeway? yes _____ no _____ What freeway? _____

What County did accident happen in? _____

What police department did the accident investigation? _____

Do you have a copy of the police report? yes _____ no _____ (we require a copy of the police report for your file – please provide a copy as soon as possible)

Name of other Driver: _____

Did other driver's insurance company accept liability? yes _____ no _____

Your Automobile insurance;

Insurance Company name _____

Address: _____

City: _____ State: _____

Phone: _____

Claim Number: _____ Policy Number: _____

Insured Name: _____

Adjuster's Name: _____

Other Driver's Insurance:

Insurance Company name _____

Address: _____

City: _____ State: _____

Phone: _____

Claim Number: _____ Policy Number: _____

Insured Name: _____

Adjuster's Name: _____

Have you retained an attorney? yes _____ no _____

Attorney Name: _____ Phone: _____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

Car Station Wagon
 Van Pickup Truck
 Large Truck Bus
Other _____

2. Your position in vehicle

Driver Front Passenger
 Left Rear Passenger
 Right Rear Passenger
Other _____

3. What was your vehicle doing at the time of the accident?

Stopped at intersection Stopped in traffic Stopped at light
 Making a right turn Making a left turn Parking
 Proceeding along Slowing down Accelerating
Other _____

4. Time/Speed/Damage

Time of accident _____
Your vehicle's
speed: _____ mph
Their vehicle's
speed: _____ mph

Damage to your vehicle

Mild Moderate
 Totaled

5. Details of Accident

Visibility at time of accident
 Poor Fair Good

Who hit who/what?

You hit other vehicle
 Other vehicle hit you
You hit...(object)

6. Road conditions

Road conditions at time of accident
 Icy Wet Sandy Dark Clean and dry

Point of impact

Head-On Left Front Right Front
 Read-End Left Rear Right Rear

7. Body Position, etc.

Did you see the accident coming? **Yes** **No**
Were you braced for the impact? **Yes** **No**
Did you have a seat belt on? **Yes** **No**
Was your shoulder harness on? **Yes** **No**
Did driver side airbag deploy? **Yes** **No**
Did passenger side airbag deploy? **Yes** **No**
Side airbags? **Yes** **No**

Does your vehicle have headrests? Yes **No**

What was the position of your headrest at the time of the impact?

Even with top of head Even with bottom of head Middle of neck

What was the direction of your head at the time of the impact?

Facing straight forward Turned to the right Turned to the left

8. During the accident:

Did your body strike inside of your vehicle? **Yes** **No**

If yes, describe: _____

Did you lose consciousness during the injury? **Yes** **No**

If yes, for how long? _____

Your vehicle's estimated damage? _____

Damage to their vehicle: Mild Moderate Totaled

Did police show up at the scene? **Yes** **No**

Was an accident report filled out? **Yes** **No**

9. After the accident:

Check off your symptoms following the accident:

Headache Dizziness Mid back pain Cold hands

Neck pain Nausea Low back pain Cold feet

Neck stiffness Confusion Nervousness Diarrhea

Fainting Fatigue Loss of taste Depression

Ringing in ears Tension Toe numbness Anxious

Loss of smell Irritability Constipation Chest Pain

Pain behind eyes Shortness of breath Sleeping problems

Others: _____

10. Emergency Room?

Where did you go after the accident?

Home Work Hospital ER Private Doctor

How did you get there?

Self Somebody else Ambulance. Police

X-rays done? Yes **No** **Lab work? Yes** **No**

Body parts X-rayed? _____

What lab work? _____

The X-rays revealed: _____

Treatments: Cervical Collar Ice **Other:** _____

Medications: _____

Follow-up instructions: _____

11. Treatment History:

Fill in other doctor(s) seen prior to your first visit to this office.

1. Dr. _____ First visit date: ____/____/____

Specialty: _____ X-rays done? **Yes** **No**

Types of treatments received: _____

How many treatments received? ____ Currently treating? **Yes** **No**

Did treatments benefit you? **Yes** **No**

Last visit date: ____/____/____

2. Dr. _____ First visit date: ____/____/____

Types of treatments received: _____

How many treatments received? ____ Currently treating? **Yes** **No**

Did treatments benefit you? **Yes** **No**

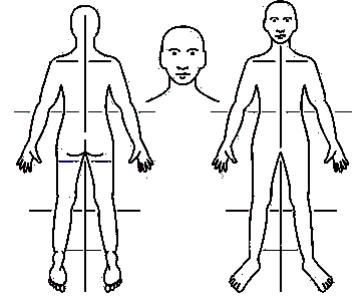
Last visit date: ____/____/____

Coyote Chiropractic & Wellness Centers, PC
Patient Health Questionnaire

Patient Name _____

Please mark the areas of complaint

Please describe your current problem _____



Is your current problem the result of: Auto Accident? Yes No

Work Accident? Yes No Slip & Fall? Yes No

How did your problem begin? _____

Date Problem began _____

Other doctors seen for this condition _____

List other treatments or tests you've had for this condition _____

Have you been treated for any other health condition by a physician in the last year? Yes No If yes, please explain: _____

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms: Sharp/Stabbing Burning Throbbing Shooting Tingling Gripping
 Dull Numbness Soreness Aches Weakness Other _____

Since it began, is your problem: Improving Getting Worse No Change

What makes the problem better? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

What makes the problem worse? Nothing Lying Down Standing Walking Sitting Movement
 Exercise Inactivity/Rest Other _____

Can you perform your daily home activities? Yes Only with help Not at all

Do you exercise? Yes, often Yes, occasionally Not at all

Describe your job requirements: Mainly Sitting Light Labor Heavy Labor Other _____

Can you perform your daily work activities? Yes, all activities Only some Not at all

Describe your stress level: None to mild Moderate High

Pediatric Records: (under 17) Are your immunizations up to date? Yes No

Please provide (to the best of your ability) complete immunization record.

Please list all allergies including allergies to medications: _____

List all medications you are presently taking (including vitamins & supplements) _____

List any surgeries, fractures, serious illnesses or hospitalizations _____

Coffee/Caffeine/Energy Drinks/Day _____ wk _____

Smoking - Packs/Day _____

Alcohol Use – Drinks/day _____ week

Drug Use _____

**Coyote Chiropractic & Wellness Centers, PC
Patient Health Questionnaire**

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- | | | |
|---|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancies |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling, Stiffness of Joints |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Tinnitus (Ear Noises) |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer (breast, prostate etc.) | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vision Disturbances |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Pain - Neck | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Pain - Mid Back | |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pain - Low Back | Height: _____ feet _____ inches |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Pain - Arm/Elbow | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain - Hand | Weight: _____ pounds |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pain - Wrist | |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Pain - Shoulder | Dominant Hand: R / L (please circle) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain - Ankle or Foot | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pain - Leg | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pain - Knee | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> PMS/PMDD | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rapid Heartbeat | |

Family Health History:

If a family member has had any of the following, please mark the appropriate box:

- | | | | | |
|---|-------------------------------------|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Lupus | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Alcoholism | Other _____ | | |

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received or reviewed a copy of this notice (available in the front reception area).

Patient name printed

Authorized Provider Representative

Patient Signature

Authorized Provider Signature

Personal representative Printed

Date

Date

Description of personal representative's authority to act for the patient.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of the date listed below as signed by the patient. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed

Authorized Provider Representative

Patient Signature

Authorized Provider Signature

Personal representative Printed

Date

Date

Description of personal representative's authority to act for the patient.

PATIENT CONSENT TO TREATMENT

Please read prior to signing. Please ask any questions if there is anything this is unclear.

The nature of the chiropractic adjustment

A primary treatment we use as a Doctor of Chiropractic is spinal manipulation therapy. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click” and you may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to procedures that we may recommend and/or discuss with you.

The material risks are inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to neck arteries leading to or contributing to serious complications including stroke. It is not uncommon to feel some stiffness and soreness following the first few days of treatment. We will make a reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures from chiropractic treatment are rare and generally result from some underlying weakness of the bone which we screen for during the taking of your history, exam and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally describes as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxant and pain-killers
- Hospitalization and/or Surgery

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read { } or have had read to me { } the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Coyote Chiropractic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I here give my consent to that treatment.

Patient’s Name

Doctor Name

Patient’s Signature

Guardian Signature if Patient is a minor

Date