



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

**Patient Information**

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**

If any signer is entitled to benefits under any insurance policy, the benefits are hereby assigned to Coyote Chiropractic for application on the patient's bill; however, **IT IS UNDERSTOOD THAT THE UNDERSIGNED AND THE PATIENT ARE PRIMARILY LIABLE FOR PAYMENT OF THE PATIENT'S BILL (including any deductible)**. It is intended by this provision to allow Coyote Chiropractic to bill and receive payments directly from the above insurance company without giving up our right to bill and collect from the undersigned all unpaid services rendered by Coyote Chiropractic. **Our office will not enter a dispute with your insurance company over any claims.** Please be advised that verification of insurance coverage is not a guarantee of benefit payments. **In the event your account is submitted to collections, you will be responsible for all associated charges and fees.**

**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

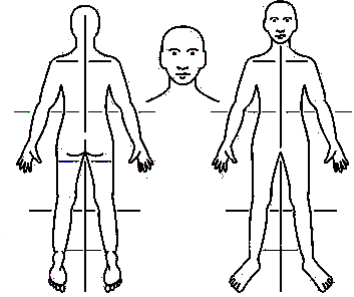
\_\_\_\_\_  
Date

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

**Please mark the areas of complaint**

Patient Name \_\_\_\_\_

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            | <b>Height: _____ feet _____ inches</b>                 |
| <input type="checkbox"/> Convulsions                    | <input type="checkbox"/> Pain - Arm/Elbow           |  |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Pain - Hand                | <b>Weight: _____ pounds</b>                            |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Pain - Wrist               |  |
| <input type="checkbox"/> Digestive Disorders            | <input type="checkbox"/> Pain - Shoulder            | <b>Dominant Hand: R / L (please circle)</b>            |
| <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