Living Pure Chiropractic
17235 N 75th Ave #F110, Glendale, AZ 85308
(623) LP CHIRO (572-4476) fax (623) 566-4918

New Patient Registration and Accident Questionnaire

Name: _____ Age: _____Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____)_____Work Phone (_____) _____

Cell Phone (_____) _____email address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____ **Relationship:** _____ **Phone (_____)** _____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms: _____

What makes your symptoms better? _____What makes your symptoms worse? _____

What is the quality of your symptoms? (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**

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 Accident: _____ Hour: _____AM _____PM _____

Specific Location of Accident: _____

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

_____

_____

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

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

Were you struck from: ☐ Behind ☐ Front ☐ Side Impact ☐ Driver's Side ☐ Passenger's Side

Were traffic citations issued to: ☐ You ☐ the Driver of Your Car ☐ the Driver of the Other Car ☐ No Citations Given

Was your car 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 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
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ Depression	☐ Blurred Vision	☐ Tingling in Arms	☐ Loss of Taste
☐ Anxiety	☐ Sensitivity to Light	☐ Jaw Pain	☐ 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 accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

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

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____ Treatment Given? _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

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Patient's Name: _____ Date: _____

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: (_____) _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date:_____

Witness: _____Date: _____

Staff Initials: _____

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HEALTH HISTORY FORM

PATIENT NAME: _____

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	Timeframe

Past family care provider(s):

Name	Address	Phone	Timeframe

Other medical providers seen in past 5 years predating collision:

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

Other medical providers seen any time in your life prior 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 NAME: _____

Prior automobile accidents with injury:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				
4.				
5.				

Prior work related injuries:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				
4.				
5.				

Prior slip/fall injuries:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				
4.				
5.				

Other injuries of relevance:

	Date	Location	Timeframe	Areas of injury
1.				
2.				
3.				
4.				

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OFFICE POLICY, ASSIGNMENT AND AGREEMENT

(Please read carefully and sign.)

Thank you for choosing Living Pure Chiropractic as your health care provider. A clear definition of our office policies will allow you, the patient and us, the doctors and clinic, to concentrate on the reason you are here-TO REGAIN AND MAINTAIN YOUR HEALTH.

Please read carefully and initial beside each statement below.

1. _____ Non-Participating Provider Insurance*: I understand that Living Pure Chiropractic, LLC may accept assignment of insurance benefits after my second visit*. However, we do require 100% of the bill to be paid at the time of your first visit. Once coverage is verified, payment due will reflect our verification of your policy. We recommend you also verify your policy coverage. Your insurance policy is a contract between you and your insurer. We are not party to that contract. The balance is your responsibility whether your insurance company pays or not. Insurance is designed to pay a percentage of your medical bills, up to the limit noted in your policy and not pay them completely. By signing this policy you are appointing our office as attorney-in-fact to treat, negotiate and cash any settlement draft or check for any outstanding balances from the treatment provided. You also give Living Pure Chiropractic, LLC power of attorney to endorse checks made out to you to be credited to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Living Pure Chiropractic, LLC reserves the right to stop accepting your medical insurance at any time due to the insurance company's lack of cooperation, delayed payments and/or denials of submitted claims. In the event you receive any checks from your insurance company for services that you have not paid us or paid us in full at the time these services were rendered, **those checks are to be turned over to a staff member within 3 (three) business days**.

2._____ Participating Provider Insurance: As participating providers, we are required to collect co-payments and deductibles up to the allowed amount determined by your insurance plan prior to each treatment or service. **Per our provider agreement it is considered fraud for us to collect from some patients and not from others**. Please be advised that should you choose not to pay your co-payments for any reason we must notify your insurance carrier and in turn they may drop you as a subscriber. In the event your insurance coverage changes to a plan where we are not participating as a provider, please refer to the above paragraph.

3. _____ Self Pay Patients: Self pay patients are asked to pay for all services prior to each treatment. Patients are required to make arrangements with the office manager in cases of financial hardship.

4. _____ I understand that I will be charged an interest fee in the amount of **2% monthly**, as provided by state law, when my account reaches 30 days past due**. If my account is not paid within 120 days** a $35 collection processing fee will be charged to my account and my account will be turned over to **US Collections West Inc** for further processing and I will be responsible for attorney fees, court costs and all accrued interest charges. No additional appointments will be made for delinquent accounts until they are brought current.

5. _____ I understand that **a $35 service fee will be added for any checks returned** for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).

6**.** _____ Minor Patients: The adults accompanying a minor, whether they are parents or guardians, are responsible for full payment regardless of custodial responsibility. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit, debit, cash or check before or at time of service.

7. _____ I understand and agree that health and accident policies are an arrangement *between my insurance carrier and me*. I hereby authorize Living Pure Chiropractic LLC to furnish information to insurance carriers concerning my illness and treatments and hereby assign Dr. Melanie Dias-Zair or Dr. Philip Zair and all other staff doctors all payments for medical services rendered to myself or my dependents until revoked in writing. Any amount authorized to be paid directly to the office will be credited to my account upon receipt.

8. _____ I understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable.

9. _____ **MISSED APPOINTMENT AND LATE CANCELLATIONS:** I understand that if I am unable to make a scheduled appointment I need to contact Living Pure Chiropractic via phone 24 hours before that scheduled appointment. Missed appointments slow your progress and prevent others in need of care from being seen. **A $25 FEE** WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS AND THOSE CANCELED WITH LESS THAN 24 HOUR ADVANCED NOTICE. This applies to chiropractic, massage and all therapies. It is my obligation to make up a missed appointment within 7 days of any cancellation. If I miss 3 visits, Living Pure Chiropractic reserves the right to discontinue our provider-patient relationship. A letter will be sent to me to notify of such.

10._____ Living Pure Chiropractic will allow 60 days from the date of filing for my insurance company to process or pay a claim. They will submit medical insurance forms as a courtesy to their patients. Arizona law allows insurance companies operating in its state no more than 30 days to process claims**.** It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Living Pure Chiropractic if there is a chance in my insurance coverage, residence or contact phone numbers.

ULTIMATELY, IT IS UP TO *ME* TO KNOW MY INSURANCE BENEFITS.

If you have any questions or concerns about the fees or services, please do not hesitate to speak with our staff. We strive to facilitate a comfortable, friendly environment where care is given on mutual terms.

_____ _____
Signature of Patient/Responsible Person Date

_____
Printed Name of Patient

Rev. 10/27/11