

Canyon Chiropractic Health and Wellness Center

Dr. Robert C. Dees, D.C.

Name _____ Address _____

City _____ State _____ Zip _____ Home phn _____ Cell phn _____

Pager _____ E-mail Home: _____ E-mail Work: _____

SSN _____ Date of birth _____ Age _____ Height _____ Weight _____

Male Female Single Married Divorced # of children _____ Name of spouse (or parent) _____

What is the name of your family physician? _____ What city are they located in? _____

Have you ever been to a Chiropractic doctor? _____ If yes, doctor name: _____ Date of last visit _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

_____ Currently or in the past have you ever experienced any

of these complaints while working? _____ If yes, please describe what activities at work that may be causing you to

experience these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes,

please explain: _____

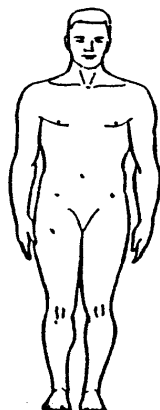
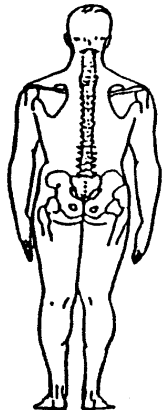
Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of injury? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Health Insurance Co. Name _____ Policyholder _____

Name of Spouse's health insurance (If applicable) _____ Policyholder _____



Method of payment for today's charges:

CASH

CHECK

CREDIT CARD

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature _____ Date _____



Health Conditions

Please check any conditions that currently exist or have existed in the past:

Severe or Frequent Headaches	Congenital Heart Defect	For women: Are you pregnant? ___Yes ___No Are you nursing? ___Yes ___No Do you experience painful periods? ___Yes ___No Do you have irregular cycles? ___Yes ___No Are you taking birth control? ___Yes ___No Do you have breast implants? ___Yes ___No
Sinus Problems	Heart Surgery/Pacemaker	
Dizziness	Heart Murmur	
Loss of Sleep	High/Low Blood Pressure	
Pain Between the Shoulders	Difficulty Breathing	
Frequent Neck Pain	Asthma	
Numbness or Pain in Arms/Legs/Hands	Arthritis	
Lower Back Problems	Alcohol/Drug Abuse	
Digestive Problems	Venereal Disease	
Ulcers/Colitis	HIV/Aids	
Heart Attack/Stroke	Diabetes	
Tuberculosis	Shingles	
Kidney Problems	Thyroid Problems	
Hepatitis	Psychiatric Problems	
Cancer	Rheumatic Fever	
Chemotherapy	Anemia	

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all expenses incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature Date

Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account:

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Worker's Comp | <input type="checkbox"/> Auto Insurance | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Personal Health Insurance | |

Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-rays are for examination of X-rays only. The X-ray negatives will remain the property of this office. All X-rays will be kept on file where they may be seen at any time while I am a patient of this office.

CONSENT TO TREATMENT OF MINOR

I/we, the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize _____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, to be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. These authorizations shall remain effective until _____, 20_____, unless sooner revoked in writing delivered to the agent(s) noted above.

Parent/legal guardian / Person having legal custody (circle relationship)

Date



NEW PATIENT INSURANCE REGISTRATION FORM

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We work with hundreds of different insurance companies that administer insurance benefits from different employers. Each employer pays an insurance premium for specific chiropractic coverage. Each plan is slightly different depending on how the employer has negotiated benefits with the insurance company. Companies often change insurance companies in an effort to secure better benefits for smaller premiums. We encourage you to become familiar with your policy maximums, percentages, exclusions, deductible and required co-payments.

We do not base your adjustment program on your insurance coverage and neither should you. There are limits to what they will pay. Our goal is to correct your problem in the shortest amount of time and in the most cost-effective manner.

Our courtesy service to you includes:

1. Researching your chiropractic insurance plan to advise you of benefits available to you.
2. Filing your insurance within 14 days of your visit and requesting payment of benefits to our office when possible.
3. Follow up on chiropractic claims to assist with claim processing and payment.

Our expectations of you as the owner of the insurance policy:

1. Payment of fees not covered by your insurance plan.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.
3. Taking responsibility for payment if the insurance company does not pay our office.
4. Keeping our office informed of any changes in your insurance coverage or employment.

To assist us in obtaining your benefits, **please sign the "assignment of benefits"** below to allow us to file your insurance claims.

I hereby authorize Dr. Robert C. Dees to release to my insurance company, information acquired in the course of my chiropractic care. I hereby authorize benefits to be paid to Dr. Robert C. Dees. I understand I am responsible for any unpaid balance.

Signature: _____

Date: _____



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

To locate, analyze, and correct spinal interference to the nervous system.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

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WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S)  
OTHER THAN VERTEBRAL SUBLUXATIONS

WE OFFER NO OTHER TREATMENT OF CONDITION(S) OR DISEASE(S)  
OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

***THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!***

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I, _____, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

SIGNATURE: _____ DATE: _____

Canyon Chiropractic _____ Dedicated to Quality Care