

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) _____

Employer _____ Address _____

City _____ State _____ Zip _____ Wk phn _____ Occupation _____

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? _____

Do you have an attorney for this work injury? ___ Yes ___ No If yes, who is your attorney? _____

Have you been involved in a car accident in the last 12 months? ___ Yes ___ No If yes, what is the date of the car accident? _____

Do you have an attorney for this car accident? ___ Yes ___ No If yes, who is your attorney? _____

How many other passengers were in the car with you during the car accident? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

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

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

Please list all medications (prescription or non-prescription) you are currently taking: Aspirin/Tylenol Pain killers Muscle Relaxers Insulin

Tranquilizers Birth Control Pills Others _____

Health Insurance Co. Name _____ Policyholder _____

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

Spouse's Health Insurance Claims address _____ Policy number _____



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.



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!!!



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