Maloney Chiropractic Clinic
2525 E. Thomas Rd. Ste. #1 | Phoenix, AZ 85016
Tel. (602)955-2858 | Fax (602)955-5522

Today's Date: ___/___/_____

PATIENT INFORMATION

Patient Name:____
Last Name First Name Middle Name

Preferred Name:______________________________________ Gender: Male/Female

Social Security: ______________________ DOB:______/_____/__________ Age: ___________
MM DD YYYY

Home Address:____ Apt. /Unit: ________

City:______________________ State: _________________ Zip: ___________________

Home Phone: ______________________________ Cell Phone: ____________________________

Your email: ____________________________________

Occupation: __________________________ Employer: ______________________ How long? __

Work Phone: _________________________

Marital Status: Single / Married / Divorced / Minor / Separated / Widowed

Spouse's Name: ____________________________

Do you have any children? Yes/No If yes, how many? __________________

EMERGENCY CONTACT

Name: _________________________ Phone: ____________________ Relation: _____________

INSURANCE INFORMATION

Insurance Carrier: ____

Policyholder's Name: ____

Policyholder's DOB: ____

Policyholder's ID#: ____

Policyholder's SS#: ____

Policyholder's Group #: ____

Relation to Policyholder: ____

ACKNOWLEDGMENT

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the manager.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office as any changes occur to the information I have provided.

Patient/Guardian Signature: _____________________________ Date: ____/____/______

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HEALTH HISTORY

Height:____________ft.   Weight:__________________lbs.   Handedness: Right / Left

Last Chiropractic Visit: ____

What was the visit for? ____

Primary Medical Doctor:__________________________________ Phone #:_____________________________

Last Medical Doctor Visit: ____

What was the visit for? ____

Prior Medical History:	When?

Surgical History:	When?

Family Medical History: ____

Allergies: ____

Medications: ____

____

Cholesterol: Yes / No	Medication: Yes / No
Diabetes: Yes / No	Medication: Yes / No
High Blood Pressure: Yes / No	Medication: Yes / No
Heart disease: Yes / No	Medication: Yes / No
Cancer: Yes / No	What type of Cancer? __________________
Blood thinners: Yes / No	
Smoker? Yes / No / Formerly	

FEMALE ONLY

Are you pregnant? Yes / No

Date of last menstrual period? ________________________   None: _____________

Pregnancies? Yes / No   If yes, how many? _______________   Oral contraceptives? Yes / No

Patient/Guardian Signature: ________________________________ Date: ____/____/______

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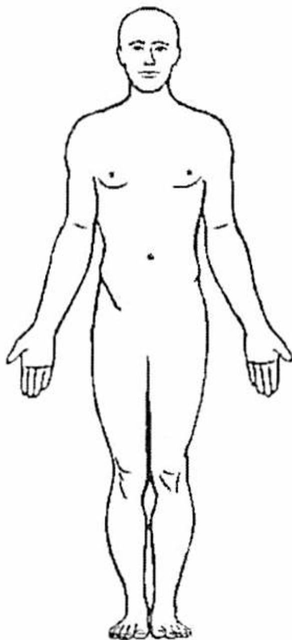
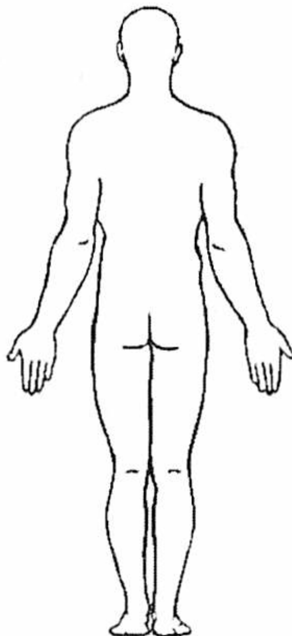
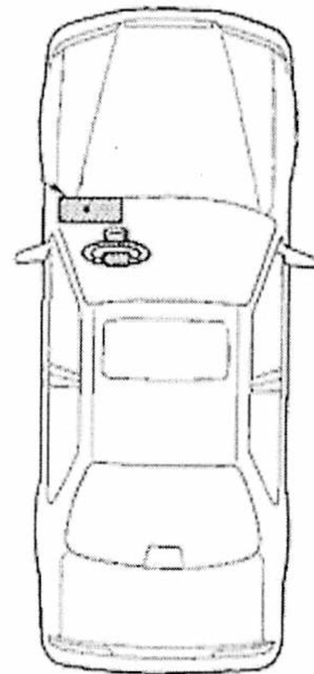
PLEASE COMPLETE THE FOLLOWING

Symptoms are related to: Auto Accident / Work Injury / Other: ____________________
When did it begin? ____
Have you been treated by another Doctor? Yes/ No When?______________________
If so, whom?____ Phone #:_________________________
Is it getting? Better / Same / Worse
Have you lost time from work? Yes / No If so, how many days?__________
Briefly describe how the accident/crash happened: ____
____
____
____







FRONT/ FRENTE BACK/ESPALDA

Please mark an X on area(s) of pain

Please mark an X on area(s) where vehicle was impacted or damaged.

Name:____

Patient/ Guardian Signature:_______________________________ **Date:**___/___/_____

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DISCLOSURE AND CONSENT

I hereby request and consent to the performance of examination, chiropractic adjustment and other procedures, including various modes of physical therapy and/or diagnostic tests including x-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Patrick Maloney, DC and/or other licensed doctors of chiropractic or those working at the clinic who now or in the future treat me while employed by, working with, or serving as a backup for Dr. Maloney. I understand I will have the opportunity to discuss with Dr. Maloney, or anyone whom may be assisting or replacing Dr. Maloney, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to treatment including, but not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious side effects such as cerebral vascular accidents are rare but will be made known at my request. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the recommended treatment.

Name of Patient: ______________________________ **FILE #:**

Patient/Guardian Signature: ______________________________ **Date:** ____/____/____

Appointment Calls, Open Room Adjusting & Health Care Information (HIPPA)

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

For the purpose of assisting you in the submission of your health care claim for payment, Maloney Chiropractic Clinic may need to disclose your name, address, phone number, billing information and clinical records to persons outside the doctor's office. By signing this form you are giving this office permission to disclose any and all information contained in your file. By signing below, you will also be giving your authorization to disclose this information to the party or parties responsible for the payment of your services and any State or Federal agencies that may be asked to intercede on your behalf or be asked to document your claim.

Maloney Chiropractic Clinic 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. By signing this form, you are giving us authorization to contact you by phone, and a message may be left with a family member or voice message machine with these reminders and information.

You can 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, you revocation must be mailed to us in writing at our office address.

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 you care.

We offer care in an open-adjusting format, with other patients in the same room. Occasionally comments about your condition and progress may be discussed while you are in this environment.

I, ______________________________ authorize you to use or disclose my (or my dependant named below) health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Name of Patient: ______________________________ **FILE #:**

Patient/Guardian Signature: ______________________________ **Date:** ____/____/____