SOUTHWEST FAMILY MEDICAL

2919 S Ellsworth Rd #102 Mesa, AZ 85212

Patient Name_____ Date: _____ Email: _____

SS#/SIN_____ DOB_____ Age_____

□ Male □Female Home phone_____ Cell Phone_____ Cell Provider _____

*Cell provider is to receive appointment reminder texts. Check here if preferred via email: ☐

Check appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated

Patient's Address_____ City _____ State_____ Zip_____

Employer Name / Occupation: _____

Spouse or Patient's Guardian Name: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

MOTOR VEHICLE ACCIDENT / WORKERS COMPENSATION ONLY:

Responsible Party

Name of The Person Responsible for this Account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured_____ Relationship to patient _____Birthdate_____

SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____City _____ State _____ Zip_____

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Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint:

_____

History of Present illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Example: normal vs abnormal color, activity, etc...)

Severity: _____ (How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____ (How long have you had this pain/ problem? When did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____

_____

(What other associated problems have you been having?)

Modifying Factors _____

_____

(What makes the pain/problem worse or better? Have you Had previous episodes?)

Past Medical History

Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES
Hepatitis	NO	YES	Mumps	NO	YES	Bladder Infection	NO	YES
High Blood Pressure	NO	YES	Ulcer	NO	YES	Chicken Pox	NO	YES
Epilepsy	NO	YES	Low Blood Pressure	NO	YES	Kidney Disease	NO	YES
Whooping Cough	NO	YES	Migraine Headaches	NO	YES	Hemorrhoids	NO	YES
Thyroid Disease	NO	YES	Scarlet Fever	NO	YES	Tuberculosis	NO	YES
Bleeding Tendency	NO	YES	Diphtheria	NO	YES	Diabetes	NO	YES
Asthma	NO	YES	Small Pox	NO	YES	Cancer	NO	YES
Hives of Eczema	NO	YES	Pneumonia	NO	YES	Polio	NO	YES
AIDS & HIV	NO	YES	Rheumatic Fever	NO	YES	Glaucoma	NO	YES
Infectious Mono	NO	YES	Arthritis	NO	YES	Hernia	NO	YES
Bronchitis	NO	YES	Venereal Disease	NO	YES	Blood or Plasma	NO	YES
Mitral Valve Prolepses	NO	YES	Transfusion	NO	YES	Stroke	NO	YES
Any Other Disease:								

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		Muscular / Skeletal		Gastrointestinal	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Abdominal Pain	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Nausea	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Vomiting	1 2 3 4 5
Sore Throat	1 2 3 4 5	Joint Pain	1 2 3 4 5	Blood in Stool	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Constipation	1 2 3 4 5
Lumps	1 2 3 4 5	Neck Pain	1 2 3 4 5	Diarrhea	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Wrist / Hand Pain	1 2 3 4 5	**Genito-Urinary**	
Masses or Growths	1 2 3 4 5	Elbow Pain	1 2 3 4 5	Blood in Urine	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Pain with Urination	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Hip Pain	1 2 3 4 5	Urgency	1 2 3 4 5
Drainage	1 2 3 4 5	Knee Pain	1 2 3 4 5	Frequency	1 2 3 4 5
Earache / Ear Infection	1 2 3 4 5	Ankle / Foot Pain	1 2 3 4 5	Difficulty Voiding	1 2 3 4 5
Itching	1 2 3 4 5	Pain Between Shoulder Blades	1 2 3 4 5	Other	1 2 3 4 5
Hoarseness	1 2 3 4 5	**Cardiovascular**		**General**	
Shortness of Breath	1 2 3 4 5	Chest Pain	1 2 3 4 5	Fatigue	1 2 3 4 5
Wheezing	1 2 3 4 5	Palpitation	1 2 3 4 5	Malaise	1 2 3 4 5
Neurological		Shortness of Breath	1 2 3 4 5	Weakness, Tiredness	1 2 3 4 5
Headaches	1 2 3 4 5	Lower Extremity Swelling	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Migraines	1 2 3 4 5	Syncope	1 2 3 4 5	Irritability	1 2 3 4 5
Dizziness	1 2 3 4 5	**Hematological**		Weight Changes	1 2 3 4 5
Numbness	1 2 3 4 5	Fever	1 2 3 4 5	Forgetfulness	1 2 3 4 5
Tingling	1 2 3 4 5	Chills	1 2 3 4 5		
Pins/Needles in Hands or Feet	1 2 3 4 5	Abnormal Bleeding	1 2 3 4 5		

Previous Hospitalizations/Surgeries/Serious Illnesses

Date of Last Chest X-Ray_____ When_____

Hospital, City, State_____ _____ _____

Medication: (Dosage and Include Nonprescription)

_____

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O Yes O No If yes, please list: _____

Allergies:

_____

_____

Patient Social History:

Marital Status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Sibling's:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

AS WELL AS AN

APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Southwest Family Medical as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy (is). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)

(Patient signature)

X_____ (SEAL)

(Signature of Guardian if applicable)

X_____

(Please print patient name)

INFORMED CONSENT TO MEDICAL TREATMENT AND PRACTICE POLICY

I hereby request and consent to the performance of medical treatment by medical provider and chiropractic adjustments and any other chiropractic or medical procedures, including examination tests, labs, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctors of chiropractic and or medical provider that are associated with Southwest Family Medical, PLLC.

I understand that, as with any health care procedure, there are certain complications, which may arise during medical treatment and/ or chiropractic adjustment. Those complications include but are not limited to: soreness, fractures, disc injuries, dislocations, and strain/sprains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with a doctor at Southwest Family Medical, PLLC the nature, purpose and risks of chiropractic adjustments, medications, and other recommended procedures and have had my questions answered to my satisfaction. I also understand that there is no guarantee or warranty for a specific cure or result.

I understand that if I suffer adverse symptoms or have concerns about my medical treatment after office hours, that it is important that I go to the ER to resolve these problems.

I have read or have had read to me the above explanation of the medical treatment and chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Additionally, I understand that there is a **$20 cancellation fee** for South West Family Medical, for any appointment cancelled within less than 24-hours of the appointment. I understand this policy is in place to better serve me and the other patients of the practice.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT SIGNATURE OR LEGAL GUARDIAN

DATE

PRINTED NAME OF PATIENT

Southwest Family Medical PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____Hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Southwest Family Medical Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for SOUTHWEST FAMILY MEDICAL to provide treatment to me, and also necessary for SOUTHWEST FAMILY MEDICAL to obtain payment for that treatment and to carry out its health care operations. SOUTHWEST FAMILY MEDICAL explained to me that the Privacy Notice will be available to me in the future at my request. SOUTHWEST FAMILY MEDICAL has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. SOUTHWEST FAMILY MEDICAL reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by SOUTHWEST FAMILY MEDICAL: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.
4. SOUTHWEST FAMILY MEDICAL may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for SOUTHWEST FAMILY MEDICAL to treat me and obtain payment for that treatment, and as necessary for SWSR to conduct its specific health care operations.
5. I understand that I have a right to request that SOUTHWEST FAMILY MEDICAL restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, SOUTHWEST FAMILY MEDICAL is not required to agree to any restrictions that I have requested. If SOUTHWEST FAMILY MEDICAL agrees to a requested restriction, then the restriction is binding on SOUTHWEST FAMILY MEDICAL.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that SOUTHWEST FAMILY MEDICAL has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, SOUTHWEST FAMILY MEDICAL has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then SOUTHWEST FAMILY MEDICAL will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Patient/Individual (Please print)	Signature of Patient/Individual
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship to Patient
Date Signed	Witness