AZ Multicare Ltd. Chiropractic Office 16700 N. Thompson Peak Pkwy., Ste. 260 Scottsdale, AZ 85260 phone 480-991-5555 fax 480-948-8295

Patient Registration and History Questionnaire

Name: _____ Age: _____ Date of birth: _____ ☐ Male ☐ Female Date: _____
LAST **FIRST** **MIDDLE**

Address: _____ City, State, Zip: _____ SSN: _____

Home Phone (____) _____ Cell Phone (____) _____ Work (____) _____

Employer: _____ Occupation: _____ Email: _____

Marital Status: ☐M ☐S ☐W ☐D # of children _____ Spouse: _____ Phone: (____) _____

How were you referred to us? ☐ Friend/Family ☐ Internet ☐ Other (Please Explain) _____

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 are your symptoms? (ache, burn, dull, sharp, throbbing): _____ Are 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

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? _____ List any allergies to medications, foods or other: _____

Please list all medications and dosage:	**Frequency**	**For What Illness?**

Please list all serious illness and serious accidents	**Month & Year**	**City, State**

Recent x-rays, lab or other tests:	**Date**	**Facility/Doctor**

FINANCIAL AGREEMENT

I UNDERSTAND THAT *AZ MULTICARE* WILL CHECK FOR INSURANCE COVERAGE FOR FUTURE CARE GIVEN TO ME AT THIS OFFICE, BUT REALIZE THAT ANY DENIAL OF PAYMENT BY MY INSUANCE COMPANY WOULD LEAVE ME PERSONALLY RESPONSIBLE FOR THE AMOUNT LEFT UNPAID.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP *AZ MULTICARE* AWARE OF ANY CHANGES IN MY INSURANCE POLICY, INCLUDING BOTH PLAN AND COMPANY CHANGES.

I ALSO UNDERSTAND THAT *AZ MULTICARE* DOES NOT ACCEPT PAYMENT FROM THE INSURANCE COMPANY AS PAYMENT IN FULL. *AZ MULTICARE* WILL REQUIRE ALL PATIENTS TO PAY THEIR FULL DEDUCTIBLE AND CO-PAYS, IN ACCORDANCE WITH INSURANCE REGULATIONS.

FINANCIAL ARRANGEMENTS CAN BE MADE THROUGH THE OFFICE MANAGER IF ANY BALANCE EXCEEDS $250.00. ANY AGREEMENT FOR PAYMENTS WILL BE DOCUMENTED, AND A COPY WILL BE SENT TO YOU FOR YOUR RECORDS.

ANY BALANCE NOT PAID WITHIN 90 DAYS WILL BE SENT TO COLLECTIONS. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL ATTORNEY FEES AND COURT COSTS SHOULD COLLECTION ACTION BE REQUIRED IN MY CASE

Patient Name: _____

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____