WELCOME TO EAST VALLEY FAMILY HEALTHCARE, PC, INC To ensure proper case information, please provide us with the following information. If you need assistance in completing these forms, please ask the front desk.

Name:				Nick	name pre	ferred:			
Date of Birth:	_//	Age:		Female _	Male	Soc Sec #	#:·		
Marital Status	_Single	Married	Divorced	Widowed					
Mailing Address						Home Phone)		
City, State, Zip						Cell Phone)		
Employer						Emai	l		
Employer Address	s								
City, State, Zip									
Emergency Contac	ct					Phone	e		
Referred by:	Yourself	Frier	nd Fam	nily Member	Insurance	e Carrier	Physici	an	
Name of person w	ho referred	l you:							
Primary Care Phys	sician:			Are y	ou curren	itly under trea	itment?		
		INSURAN	ICE (plea	se give insuran	ce card	to front de	esk)		
Insurance Company									
Insurance ID#									
Policy Holder				ation to Patient					
Is the patient covere	ed by additio	nal insurance?					•		
	=			Phone Number			Policy ID#		
Do you have a HF				Do you have a HSA					
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Date of Accident				Type of Accident			Othe	er	
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Attorney Name (if app							e	-	
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HEALTH HISTORY Please advise us of any special circumstances, previous tests, therapies or conditions. Are you allergic to any medications? YES If yes, please list all that you are allergic to below. _____ Physical Exam X-Ray MRI ____CT Scan Date of Last: List any **Medications** you are taking (prescription and over the counter): Have you had any: Automobile Accidents Yes / No If Yes, Date If Yes, Date _____ Surgeries Yes / No If Yes, Date **Head Injuries** Yes / No **Broken Bones** Yes / No If Yes, Date Are you now, or could you be pregnant? Yes No FEMALES ONLY: First day of last menstrual cycle: Check each condition with "C" for Current, "P" for Past, or "N/A" for Not Applicable. AIDS / HIV ____Digestion Problems High Blood Pressure Shortness of Breath Earache Stroke Anxiety / Depression Insomnia Arthritis Epilepsy Kidney Problems TMJ Ulcers Asthma Headaches Osteoporosis Cancer _Headaches (Migrane) ____Prostate Problems ____Vertigo / Dizziness Rheumatoid Arthritis Heart Disease Other Chronic Fatigue Diabetes Herniated Disk Sciatica INFORMED CONSENT FOR TREATMENT I hereby request and consent to the performance of medical procedures and/or chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, muscle therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed chiropractor and massage therapists who now or in the future treat me while employed by, working at, associated with, or serving as back-up for the chiropractor and/or massage therapists working at East Valley Family Healthcare, PC, Inc. or any other affiliated office and/or clinic. I have had an opportunity to discuss with the doctor of chiropractic treating me at East Valley Family Healthcare, PC, Inc. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read, or have had read to me, the above consent. I have also had the opportunity to ask guestions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I certify that the above information is correct. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice. TO BE COMPLETED BY PATIENT Signature of Patient Patient Name PLEASE PRINT Date Signed Witness of Signature TO BE COMPLETED BY PATIENT OR BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED Signature of Patient _____ Patient Name and/or Representative Signature of Witness Date Signed Translated By (if applicable) Date____