



WELCOME

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work or Cell#: (____) _____

Date of Birth: _____ SSN#: _____ Gender: Male Female

Marital Status: Married Single Divorced Widowed

Occupation: _____

Patient's Employer/School _____

How did you hear about our office? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home: (____) _____ Cell/Other: (____) _____

INSURANCE INFORMATION

IF YOU HAVE YOUR INSURANCE CARD, PLEASE HAVE IT AVAILABLE TO COPY.

Name of Insured: _____ Date of Birth: _____

Insured's Employer: _____ Relation to Patient: _____

Insurance Company: _____ ID# _____

Insurance Phone: _____

PAYMENT AGREEMENT/PROFESSIONAL CONDUCT

I understand that I am financially responsible for all charges on my account whether or not they are paid by my insurance. I agree to pay interest on any unpaid balance regarding this account of 1.5% per month (18% per annum). If it becomes necessary to refer the account to a collections agency, I agree to pay a collection fee of 35% of the outstanding balance owing. Further, I agree to pay for any and all attorney's fees and court costs incurred. I authorize the release of any medical and or other information necessary for obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. I also authorize and assign payment of medical and government benefits to this office.

For any discount rate on services, payment must be made at the time of service.

I understand that **any remarks or actions that may be construed as illicit or sexually suggestive** will result in immediate termination of the myotherapy session, and I will be held liable for payment of the full scheduled amount.

Patient/Guarantor Signature

Date

66 EAST STATE ROAD PLEASANT GROVE, UT 84062 (801) 796-7961

MOUNT MAHOGANY

CHIROPRACTIC & MYOTHERAPY

Patient Name: _____ Date: _____

CURRENT CONDITION

What hurts today? _____

When did your symptoms appear? _____

Is your condition getting worse? Yes No Unknown Is it getting better? Yes No

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____

How often do you have this type of pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation Other _____

Activities that are difficult to perform Sitting Standing Walking Bending Lying Down

Have you had any falls or accidents? No Yes Date: _____ Type: Auto Work Other

Have you had a professional massage before? No Yes Last Massage? _____

Have you ever had chiropractic care before? No Yes Last Adjustment? _____

Have you ever had a chiropractic adjustment immediately following a massage? No Yes

How many hours/day do you spend ___ Sitting ___ Standing ___ Light Labor ___ Heavy Labor

How often do you exercise? None Moderate Daily Activity (swim, run, etc.) _____

HEALTH HISTORY: Circle all that apply. Write name of other conditions.

HEAD: Headaches—mild—moderate—severe NONE Other: _____

SPINE: Congenital disorders—Scoliosis—Herniated disc—Sciatica NONE Other: _____

NECK: Swollen glands—Thyroid problems—Herniated disc NONE Other: _____

ARM/HAND: Pain in arm— Hand numbness—Shoulder pain—Tingling—Wrist NONE Other: _____
pain

LEG/FOOT: Pain in legs—Knee pain—Hip pain—Ankle pain—Tingling— NONE Other: _____
Foot pain—Numbness in foot

NEURO: Convulsions—Seizures—Fainting—Stroke NONE Other: _____

PYSCH: Depression—Anxiety—Stress/Excess worry—Drug/Alcohol NONE Other: _____
issues—A.D.D.

EYES: Visual problem—Blurry vision—Red eyes NONE Other: _____

NOSE: Nasal allergies—Nose bleeds—Sinus problems NONE Other: _____

THROAT: Swallowing difficulty—Frequent sore throats—Speech problems NONE Other: _____

MOUTH: Dental problems—Tongue problems—Canker sores NONE Other: _____

CHEST: Asthma—Shortness of breath—Cough NONE Other: _____

HEART: Chest pain— Murmurs—Palpitations—Valve problems—Angina NONE Other: _____

INTESTINAL: Colitis—Ulcer gastritis—Esophagus problems—Polyps— NONE Other: _____
Constipation

URINARY: Urinary problems—Urinary frequency—Burning—Kidney stones NONE Other: _____

GENITAL: Infection—Warts—Impotence—Sexual difficulty NONE Other: _____

SYSTEMIC: Weight loss—Fever—Sleeping diff—Loss of energy—Arthritis NONE Other: _____

Medications: Name _____ Condition _____

Name _____ Condition _____

Name _____ Condition _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

MOUNT MAHOGANY

CHIROPRACTIC & MYOTHERAPY

Patient Name: _____ Date: _____

INFORMED CONSENT

Please discuss any questions or concerns with the staff or doctor before signing this consent.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I hereby request and consent to the following treatments and procedures initialed below:

_____ Soft Tissue (Muscle) Work / Myotherapy

_____ Chiropractic Adjustments

_____ Stretches/Exercises

_____ Other: _____

_____ Other: _____

Signature: **X** _____

PRIVACY NOTICE

Mount Mahogany, P.C.'s privacy notice guarantees, but is not limited to the following:

Mount Mahogany, P.C. will not release any of your personal information, including but not limited to: your name, address, and phone number, nor any of your health information including but not limited to: diagnosis, treatment, or other healthcare operations without your express written consent, except as needed for billing and collection purposes.

Mount Mahogany, P.C. will never sell or otherwise use your personal or health information for outside marketing purposes. We reserve the right to use your personal information for our own internal marketing purposes.

Any questions regarding the comprehensive privacy notice may be addressed by consulting the policy on public display in the office. You may request a copy for your own reference at any time. In the case of a discrepancy between this notice and the comprehensive privacy notice, the comprehensive privacy notice will be considered legal and binding.

I acknowledge that I have received the Privacy Notice.

Signature: **X** _____

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