CHIRO PLUS
3220 Brea Canyon Rd., Suite F, Diamond Bar, CA 91765
Tel (909) 598-7868 Fax (909) 598-4428

PATIENT HEALTH QUESTIONNAIRE

DATE__________________

Last Name ____

First Name __________________ Middle Initial ______ Nickname __________________

Address____

City __________________________ State _______ Zip __________

Home Phone (_____)______-______________ Cellular # (_____)______-______________

Work Phone (_____)______-______________ ext #_________ Email __________________

Soc. Sec #__________________ Drivers License # __________________

Birthday:____/____/____ Age:_________ Sex: M / F Marital Status: M S W D

Occupation ______________ Employer ______________ Years Employed _________

Address____

City ______________________ State _________ Zip ___________-___________

Spouse's Name ______________________ Soc. Sec.# ______________________

Occupation ______________________ Employer ______________________

Person Responsible for this Account ______________ Health Plan ______________

Subscriber's Name ______________________ ID# __________ Group# __________

1. **How did you hear about our office?** ______________________________
2. **Is your injury related to work?** NO YES
   If Yes, date of injury _____/_____/_____
   Did you the report injury to your supervisor NO YES
3. **Is your injury related to an auto accident?** NO YES
   If Yes, date of accident _____/_____/_____
   Was a police report filed? NO YES
4. **How do you intend on paying for today's visit?** ______________________________
5. **Please list the name of the doctor who cares for you & your family** ______________________________

CONSENT TO TREATMENT OF A MINOR CHILD:

I hereby authorize Dr. _____________ and whomever he may designate as his assistant to administer treatment as he deems necessary.

SIGNED (PATIENT OR LEGAL GUARDIAN) __________________________ DATE ______________

AUTHORIZED TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to above named physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described on attached claim.

SIGNED (PATIENT OR LEGAL GUARDIAN) __________________________ DATE ______________

PAYMENT OF SERVICES:

I realize that this may not represent the full payment for services rendered and I will be responsible for balance due.

SIGNED (PATIENT OR LEGAL GUARDIAN) __________________________ DATE ______________

AUTHORIZATION TO RELEASE INFORMATION:

I Hereby authorize above named physician to release any information acquired in the course of my examination or treatment.

SIGNED (PATIENT OR LEGAL GUARDIAN) __________________________ DATE ______________

AUTHORIZATION TO RELEASE INFORMATION:

I authorize Jeffrey Monahan, D.C. to release any X-rays taken at Chiro Plus to radiologist, Tracy Hoyt, D.C. for diagnostic review. I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that this office will prepare initial billings to assist me in making collections from the insurance company and that any amount authorized will be credited to my account on receipt. I clearly understand and agree that I am responsible for payment of all services rendered to me.

SIGNED (PATIENT OR LEGAL GUARDIAN) __________________________ DATE ______________