## Why Chiropractic?

Stage 1\_\_\_\_ Pain Relief: Just get rid of the pain. Relief is short term.

Stage 2\_\_\_\_ Rehabilitation: Get rid of the pain and fix this problem so that it does not return.

Stage 3\_\_\_\_Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive/ wellness plan which includes exercise and chiropractic.

What treatment have you already received? () Medication () Surgery () Physical Therapy			
() Chiropractic () X-rays/MRI () Other			
Exercise: ( ) None ( ) Moderate ( ) Daily ( ) Heavy			
Work Activities: () Sitting () Standing () Light Labor () Heavy Labor			
Surgeries: (please list)			
Medications: (please list)			
Place an X to indicate if you have any of the following:			
() Arthritis	() Goit	() Parkinsons Disease	
() Asthma	() Heart Disease	() Pinched Nerve	
() Bleeding Disorders	() Hepatitis	() Pneumonia	
() Breast Lump	() Hernia	() Polio	
() Bronchitis	() Herniated Disk	() Prostate Conditions	
() Cancer	() High Cholesterol	() Prosthesis	
() Diabetes	() Kidney Disease	() Rheumatoid Arthritis	
() Emphysema	() Liver Disease	() Stroke	
() Fractures	() Migraine Headaches	() Thyroid Problems	
( ) Glaucoma	() Osteoporosis	() Tumors	
() Goiter	() Pacemaker	() Ulcers	

I hereby authorize Guadamuz Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatments necessary to treat my condition.

Signature:\_\_\_\_\_

## Guadamuz Chiropractic 1695 S. San Jacinto Ave. Ste. O San Jacinto, CA 92583 (951) 654-5900/www. DoctorGChiro.com

Patient Information         Patient Name:	Insurance         Who is responsible for this account?:         Relationship to insured?:         Insurance Company:         Insurance Company:         S.S and/or Policy Number:         Group#         Other Insurance ( )yes ( )no         Subscribers Name:         DOB:         Insurance Company:         Group#         DOB:         Insurance Company:         Group#         Insurance Company:         Insurance Company:         Group#         Insurance Company:         In order to receive the best care possible within your maximum limits it is important you comply with our financial
Accident Information         Is your condition a result of an accident?         ( ) yes ( ) no         Date of injury:         Type of Accident: ( ) Auto ( ) Work         ( ) Other         Insurance Company:         Claim #         Attorney Name:         Attorney Address:         Phone #	<ul> <li>policy.</li> <li>1. Payment is expected at time of service in the form of an office visit, deductible, co-payment, or co-insurance.</li> <li>2. Your policy is contract between you and the insurance company and you are responsible for any unpaid or denied claims.</li> <li>3. If your insurance company sends you checks, it is your responsibility to deliver them to our office within 5 days.</li> <li>4. Affordable payment plans or hardship arrangements are available in special cases.</li> <li>5. Cancellations must be made within 24 hours of scheduled appointment or you will be charged for ar office visit on the third occurrence.</li> <li>"I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign insurance payments for chiropractic services rendered to me or my dependents by Dr. Guadamuz to Dr. Guadamuz."</li> <li>I have read and understand the above statement.</li> </ul>