COMMUNITY HEALTH AND WELLNESS
Living Pain Free

Dr. Ron T. Dummar DC, MAOM
Natural Health Physician
Acupuncture - Chiropractic - Herbal Medicine

345 West 600 South #401 • Heber City, UT 84032 • Phone (435) 657-3696 • Fax (435) 657-3697

ABOUT YOU

Full Name: _____
What do you prefer to be called? _____
Date of Birth: _____ Age: _____ Sex: M F
Race: Caucasian/Asian/Black/Native Hawiian/Indian/Hispanic
Primary Language: _____
Social Security #: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Cell: (_____) _____
Email: _____
Pediatrician: _____
Who may we thank for this referral? _____

In the event of an emergency:

Contact: _____
Phone: (_____) _____ Relationship: _____

CONSENT TO TREAT A MINOR

I hereby authorize the physicians at Community Health and Wellness and whomever they may designate as their assistants, to administer treatment and X-Rays as they deem necessary to my son/daughter.

Signature: _____ Date: _____
Relationship to Minor: _____

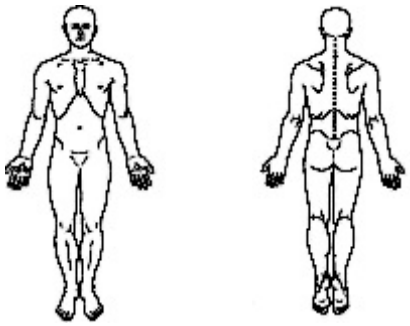
PRESENT COMPLAINT

List your current complaints (from most to least severe)

#1. _____
Briefly describe complaint:

#2. _____
Briefly describe complaint:

Please indicate on the figures below the areas of the body where complaint is experienced: (If applicable)



ASSIGNMENT OF BENEFITS • RELEASE • RESPONSIBILITIES

We invite you to discuss any questions you may have regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I hereby authorize payment of benefits directly to the provider of benefits due me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed by indebtedness to the assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I further authorize physician and/or supplier to release information required to process insurance claims. Should my contract prevent payment, I request that any draft issued me, be made jointly payable to Community Health and Wellness, PLLC.

- I understand it is my responsibility to inform this office of any changes in my medical status.
- If I need to cancel an appointment, I will call **24 hours in advance** so another patient can be booked in my time slot. A "no show" without cancellation notice may result in a **$25.00 fee**.
- I understand that it is important to be **on time** for my appointments. Out of respect for other patients who come on time, I may be asked to reschedule if I arrive more than 10 minutes later than my scheduled appointment time.

Signature of Responsible Person: _____ Date: _____

MEDICAL HISTORY

FAMILY HISTORY

	Heart Disease		Mental Illness		Allergies		Asthma
	Hypertension		Diabetes		Birth Defects		Other
	Cancer		Arthritis		Tuberculosis		

IMMUNIZATION HISTORY

Has your child been immunized according to the recommended schedule? Yes No
Has your child received any vaccinations within the last month?

Has your child had any of the following illnesses:

	Chicken Pox		Mumps		Scarlet Fever		Rheumatic Fever
	Measles		Rubella		Pneumonia		Strep Throat

SLEEPING HISTORY

Does your child regularly fall asleep in the car seat? Yes No
What position does your child usually sleep in? Stomach Back Side
Does your child wake up at night? Yes No What is the reason? _____
Does your child have night sweats? Yes No

CHILD HISTORY (2-12)

Have or did any of the following occur within the last 3 months:

	Any type of Fall		Scoliosis, Shoulder hike, Hip hike		Asthma
	Sports Accident		Dizzy spell, Reduced appetite, Fatigue		Allergies, Eczema
	Car Accident		Hyperactivity/Autism		Hospitalizations/Surgeries
	Stomach Pain		Learning Difficulties		Nose Bleeds, Easy Bruising
	Body Odor		Nightmares, unusual fears		Bedwetting

ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

I, _____, have read a copy of this office's Notice of Privacy Practices. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

I understand that a full printout of the Privacy Practices of this office will be available to me at my request.

Printed Name: _____ Signature: _____ Date: _____