

KOVACS



CHIROPRACTIC & NUTRITION CENTER

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

Patient Data

Name _____ Date _____ Email _____
 Mr. Mrs. Ms. Miss Dr. Male Female
Your email will NOT be shared with any 3d parties, and is used for monthly newsletters articles and also health education seminar dates.

Mailing address

Address _____ City _____ State _____ Zip _____
Telephone (home) _____ (cell) _____ (work) _____
Referred By Shopper Word of Mouth Patient Drive By Walk In Website Other _____
Age _____ Birth date _____ Social Security # _____ Number of children _____
Occupation _____ Employer _____
Marital Status Married Single Divorced Widow
Spouse's name _____ Spouse's Occupation _____ Spouse's employer _____
Emergency contact _____ Phone _____

Current Complaints

Date of onset _____ Is this due to an automobile accident* Yes No
Please describe _____
Date of injury _____ Date symptoms appeared _____
Have you ever had same condition? No Yes If yes, when? _____
List other practioners seen for this injury/condition _____
Have you ever been under chiropractic care? No Yes
If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____
Do you have health insurance? No Yes Name of company _____
*** If an auto accident please provide:**
Insurance company name _____ Contact person _____
Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe _____

Date of last physical exam _____. Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What **medications** are you taking and for what conditions (Please list dosage and amounts, etc).

What **vitamins, minerals, or herbs** do you currently take? (Please list for what condition, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

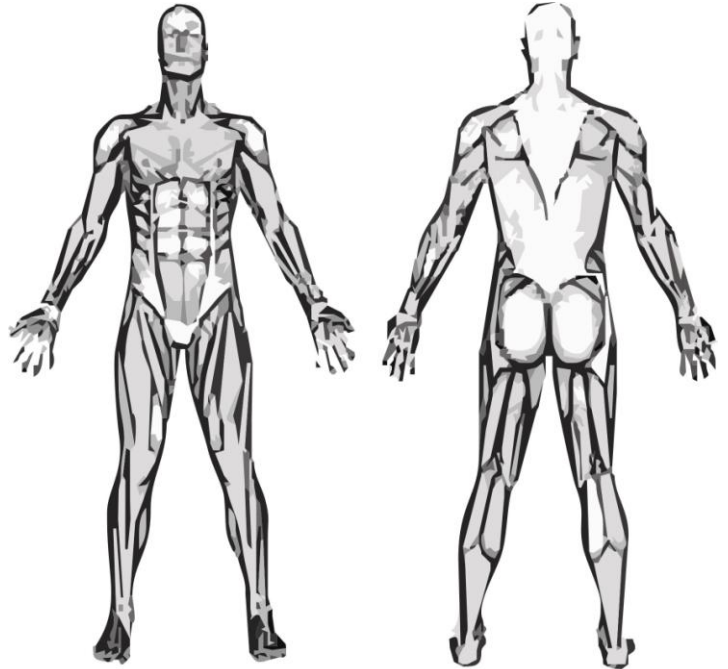
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing



Do you experience pain every day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do your symptoms interfere with daily life?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does pain wake you up at night?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are your symptoms worse during certain times of the day?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do changes in weather affect your symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wear orthotics?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you take vitamin supplements?	<input type="checkbox"/> No <input type="checkbox"/> Yes
What activities aggravate your symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes

What goals and expectations do you have?	
<input type="checkbox"/>	Relief from pain and symptoms
<input type="checkbox"/>	Chiropractic wellness care
<input type="checkbox"/>	Nutritional and herbal support
<input type="checkbox"/>	Diet and lifestyle improvement
<input type="checkbox"/>	Weight management
<input type="checkbox"/>	Detox and purification
<input type="checkbox"/>	Relief from allergies
<input type="checkbox"/>	Other: _____

Printed Name: _____

Date: _____

Signature: _____

Date: _____

Parent/Signature: _____

Date: _____

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CHIROPRACTIC & NUTRITION CENTER

OFFICE POLICY

Welcome to Kovacs Chiropractic & Nutrition Center. Dr. Kovacs and his staff are dedicated to providing you with the finest in chiropractic and nutritional health care! Please take a moment to acquaint yourself with our office policies. Our policies are designed to enhance your doctor patient relationship.

FINANCIAL ARRANGEMENTS: Payment for care is due at the time of service for all co-pays, chiropractic treatments, exams, nutritional evaluations, consultations, and nutritional supplements. Cash, checks, Visa, and MasterCard are accepted.

NEW PATIENTS: All new patients to our clinic will have a **new patient exam**. Your first appointment will consist of an exam and an adjustment. If going through insurance, you will be charged for the new patient exam and any adjustment procedures that were done during the first appointment. If you are self-pay, the fee of the **new patient exam** and the adjustment procedure will be due at time of service. Any additional appointments will consist only of adjustments to specific regions of the body. If you have any questions please ask our staff or the doctor.

ALL MEDICARE PATIENTS: Medicare and most secondary insurances do not pay for **New Patient Exam** procedures. Although we will bill the exam through your insurance company, Medicare will not pay for the **new patient exam**. The **new patient exam** will be billed to you for the first appointment you had in our office. It may be 30-60 days before this gets processed through your insurance and you receive a bill. Medicare does however cover the actual adjustments or chiropractic treatments you will receive.

INSURANCE PATIENTS: We are providers for Blue Cross Blue Shield and Medicare. **Co-pays are paid at the time of services** after benefits are determined. Until insurance benefits are verified by our staff, you are considered a cash patient. Patient acknowledges that insurance coverage verification which is obtained from insurance carriers by this facility is not a guarantee of benefits and that benefits are determined as claims are processed. If we are unable to obtain reliable information from your carrier, we cannot take assignment on your insurance; however, we will be happy to provide itemized bills. Acceptance of assignments is a courtesy representing a 60 day line of credit. You must understand and agree that health insurance policies are an agreement between the insurance carrier and yourself. We use a billing service for all of our chiropractic insurance related appointments. After verifying your benefits at our office the billing service will be submitting visits directly to the insurance company. Any questions regarding the submittal process of the appointments can be directed to the billing service. **PLEASE DIRECT ALL INSURANCE RELATED INQUIRIES TO COMPU-MED BILLING SERVICES, PHONE: 1-877-848-3757.**

NUTRITION PATIENTS: All nutrition patients are required to pre-pay their first nutritional evaluation appointment fee of \$75.00 at the time the appointment is scheduled. If you need to cancel or re-schedule this appointment, **the \$75.00 is non-refundable.** Any follow-up nutrition appointments will require a 24 hour notice if you need to cancel or re-schedule.

APPOINTMENTS: For your convenience, patients are seen on an appointment basis. We respect that your time is valuable too! Kindly give 24 hours advance notice, when possible if you must reschedule or cancel an appointment. If you are a first time chiropractic patient, you must give a 24 hour advance notice to reschedule. If you do not call to reschedule or cancel prior to your scheduled appointment you may be billed for the scheduled treatment. Leaving a message is acceptable. Should our facility need to contact you regarding appointment times or treatment, we will do so by calling the contact numbers you have provided. If necessary, a voice message will be left at these locations unless you provide written instructions otherwise.

LATE PATIENTS: If you come in after your appointment time you may have to be re-scheduled or have to wait for an opening depending on the type of appointment you had scheduled.

WALK INS: We do our best to accommodate those in acute pain. Please do not abuse this service.

CHILDREN AS PATIENTS: Parents are expected to accompany children during examination. No child will be treated unless parents have signed and authorized treatment for their child.

*****PLEASE DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING IT*****

I have read and acknowledge the office policies of
Kovacs Chiropractic & Nutrition Center:

SIGNATURE _____ DATE _____

CHILDS NAME (PRINTED) _____ DATE _____

PARENTAL SIGNATURE _____ DATE _____

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CHIROPRACTIC & NUTRITION CENTER

Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. The law requires us to give you this Disclosure, please realize that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information as follows:

- *We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- *We may have to disclose your health information to another party if they are responsible for payment of services.
- *We may need to use your health information for operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be closed or used or disclosed. You have the right to review that notice before you sign the consent form (164.520). We reserve the right to change our privacy practices as described in the notice. If we change are practices we will notify you in writing or when you come in for treatment.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals companies, or organizations. If you would like to place any restrictions on your health records please notify us in writing. We are not required to agree to your restrictions, however if we agree with your restrictions the restrictions are binding to our clinic.

Your right to revoke your authorization

You may revoke your consent to us at any time; however the revocation must be in writing. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of the notice.

Printed Name

Signature

Date

No Copy Necessary _____

Initials