

## WELCOME TO OUR OFFICE

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. PLEASE PRINT

### CONFIDENTIAL PATIENT INFORMATION

Account# \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address: \_\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S M D W # Children: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Emergency Contact (outside of your household): Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Would you like to be placed on our E-mail list? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please provide E-mail address: \_\_\_\_\_

Briefly explain the problem that is bothering you: \_\_\_\_\_

\_\_\_\_\_

When did current symptoms begin? \_\_\_\_\_ If accident what type: \_\_\_\_\_

\_\_\_\_\_ Other doctor(s) seen for this condition: \_\_\_\_\_

\_\_\_\_\_

Were x-rays taken? \_\_\_\_\_ Date and location x-rays taken: \_\_\_\_\_

List any fractures or previous surgeries: \_\_\_\_\_

\_\_\_\_\_

Have you been treated by a doctor for any health condition in the past year? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

\_\_\_\_\_

List current medication/drugs you are taking: \_\_\_\_\_

\_\_\_\_\_ Date of last physical: \_\_\_\_\_

Is there a possibility that you are pregnant? Yes \_\_\_\_\_ Due Date \_\_\_\_\_ No \_\_\_\_\_ Unknown \_\_\_\_\_

Have you had chiropractic treatment before? \_\_\_\_\_ If so, by whom? \_\_\_\_\_

Location: \_\_\_\_\_ When: \_\_\_\_\_ Results: \_\_\_\_\_

PLEASE CONTINUE ON REVERSE SIDE

**Clinic Policy requires payment be made at the time services are rendered.**

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

INSURANCE DATA: Do you have insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Patient is: Subscriber \_\_\_\_\_ Spouse \_\_\_\_\_ Dependent \_\_\_\_\_

Subscriber name if other than patient: \_\_\_\_\_ Social Security # \_\_\_\_\_

Please list all sources of insurance:

Insurance Co.: \_\_\_\_\_ ID# \_\_\_\_\_

Additional Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Medicare ID# \_\_\_\_\_ If worker's compensation please provide employer contact and phone #: \_\_\_\_\_

HAS YOUR DEDUCTIBLE BEEN MET FOR THIS YEAR? Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown \_\_\_\_\_

If visit due to an injury is an Attorney representing you? Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**INSURANCE ACCOUNTS FINANCIAL RESPONSIBILITY AND AUTHORIZATION**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment of all services rendered regardless of any insurance policies in effect. **I authorize the release of any medical or other information to my insurance carrier necessary to process claims for services rendered. I also authorize my insurance carrier to make payment of medical benefits directly to provider, John S. Kovar, D.C..** If for any reason the account should become delinquent, I agree to pay for all rebilling charges, interest charges, collection costs, and reasonable legal fees.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CASH ACCOUNT RESPONSIBILITY**

I understand that I am fully responsible for all charges. I also understand that payment is due at the time services are rendered. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, interest charges, collection costs, and reasonable legal fees.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

John S. Kovar, D.C.

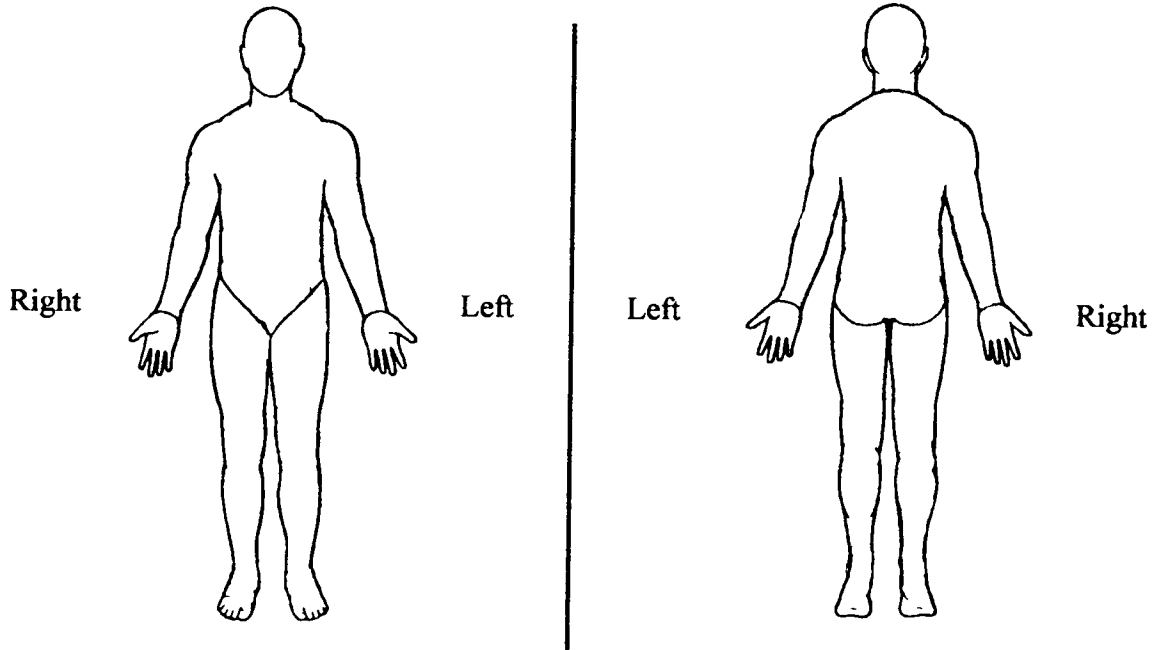
**PATIENT HEALTH AND HISTORY FORM PAGE 1**

Chief Complaint: \_\_\_\_\_

Secondary Complaint: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female Right or left handed?

PLEASE MARK PICTURES BELOW INDICATING WHERE SYMPTOMS ARE LOCATED:



Front View

Back View

**Check symptoms that apply to your condition:**

- \_\_\_ Low back pain
- \_\_\_ Leg pain \_\_\_right \_\_\_left
- \_\_\_ Pain between shoulder blades
- \_\_\_ Neck pain
- \_\_\_ Arm pain \_\_\_right \_\_\_left
- \_\_\_ Joint pain; where? \_\_\_\_\_
- \_\_\_ Joint stiffness; where? \_\_\_\_\_
- \_\_\_ Headaches
- \_\_\_ Difficulty chewing
- \_\_\_ Clicking jaw
- \_\_\_ Soreness; where? \_\_\_\_\_
- \_\_\_ Burning; where? \_\_\_\_\_
- \_\_\_ Numbness; where? \_\_\_\_\_
- \_\_\_ Pain in trapezius (across top of shoulders)

- \_\_\_ Dizziness
- \_\_\_ Forgetfulness
- \_\_\_ Confusion
- \_\_\_ Depression
- \_\_\_ Fainting
- \_\_\_ Convulsions
- \_\_\_ Cold in upper extremities; where? \_\_\_\_\_
- \_\_\_ Cold in lower extremities; where? \_\_\_\_\_
- \_\_\_ Tingling in upper extremities; where? \_\_\_\_\_
- \_\_\_ Tingling in lower extremities; where? \_\_\_\_\_
- \_\_\_ Change in bowel habits
- \_\_\_ Change in bladder habits
- \_\_\_ Paralysis
- \_\_\_ Other: \_\_\_\_\_

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Acct. # \_\_\_\_\_

**JOHN S. KOVAR, D.C.**

**FAMILY MEDICAL HISTORY**

Please check the illnesses which are present in your family history, as well as, which relative has the history of the illness.

ILLNESS	SELF	MOTHER	FATHER	BROTHER OR SISTER	OTHER
Cancer					
Diabetes					
Heart Problems					
HIV/AIDS					
Arthritis					
Lung Disorder					
Liver Disorder					
Scoliosis					
Seizures					
High/Low Blood Pressure					
Tumors					
Stroke					
Thyroid Disorder					
Low Back Pain					
Urinary Problems					
Headache					
Hepatitis					

**SOCIAL HISTORY**

Do you: drink alcohol? \_\_\_ no, \_\_\_ yes, amount and frequency \_\_\_\_\_

smoke? \_\_\_ no, \_\_\_ yes, amount daily \_\_\_\_\_, how long have you smoked? \_\_\_\_\_

exercise? \_\_\_ no, \_\_\_ yes, how frequently and what type? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_ How often do you eat meals? \_\_\_\_\_

Special dietary needs: \_\_\_\_\_

For women: Are you currently using birth control? \_\_\_ no, \_\_\_ yes; method \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Are you pregnant? \_\_\_ no, \_\_\_ yes;

due to deliver when? \_\_\_\_\_ Are you nursing? \_\_\_ no, \_\_\_ yes

**Date:** \_\_\_\_\_ **Patient Name:** \_\_\_\_\_ **Acct. #** \_\_\_\_\_

**PATIENT HEALTH AND HISTORY FORM PAGE 3**

Is your condition improving\_\_\_\_, same\_\_\_\_, worse\_\_\_\_? Are symptoms constant\_\_\_\_ or intermittent\_\_\_\_\_?

Check the following activities that aggravate your condition: \_\_\_standing, \_\_\_ walking, \_\_\_sitting, \_\_\_ lying, \_\_\_bending, \_\_\_lifting, \_\_\_twisting, \_\_\_coughing, \_\_\_sneezing

Is your condition affecting your sleep?\_\_\_yes, \_\_\_no, Affecting daily activities?\_\_\_yes, \_\_\_no, If so, in what way?\_\_\_\_\_

Have you missed work due to current condition?\_\_\_no, \_\_\_yes, how long?\_\_\_\_\_ Do you have to work light duty?\_\_\_no \_\_\_yes, in what way?\_\_\_\_\_

What reduces your pain?\_\_\_\_\_

Are you currently taking any of the following medications?\_\_\_nerve pills, \_\_\_pain killers, (including over the counter medications), \_\_\_muscle relaxers, \_\_\_stimulants, \_\_\_blood thinner, \_\_\_tranquilizers, \_\_\_insulin, other: (please specify)\_\_\_\_\_

List any **past** serious accidents including date (or age at time):\_\_\_\_\_

List all past hospitalizations including date (or age at time):\_\_\_\_\_

**Date:**\_\_\_\_\_ **Patient Name:**\_\_\_\_\_ **Acct. #**\_\_\_\_\_