



CHIROPRACTIC CASE HISTORY



CONFIDENTIAL PATIENT INFORMATION

DATE: _____

Patient Information: (please print)

Last Name _____ First _____ M _____ Social Security Number _____ / ____ / ____ Age _____
 Address _____ City _____ State _____ Zip _____ (____) _____ - _____ Home Phone _____
 Occupation _____ Employer _____ (____) _____ - _____ Cell Phone _____
 Employer Address _____ City _____ State _____ Zip _____ (____) _____ - _____ Work Phone _____
 E-Mail Address (if applicable) _____ M S W D Male Female # of Children (if applicable) _____
 Marital Status Sex

How were you referred to our office? Location Yellow Pages PCP Patient (Name) _____
 Insurance Company _____ Event _____

Spouse or Parent Information: (Parent if patient is minor)

Name _____ MI _____ Date of Birth _____ / ____ / ____ Age _____ Social Security Number _____
 Occupation _____ Employer _____
 Employer Address _____ City _____ State _____ Zip _____ (____) _____ - _____ Work Phone _____

Medical History:

Date of your last physical: ____/____/____ Who is your PCP? _____

What, if any, operations have you had? _____ When _____
 What, if any, serious illnesses have you had? _____ When _____
 Have you been treated for any health condition by a physician in the last year? No Yes
 If Yes, Describe: _____
 What, if any, medications are you taking? _____
 Have you or any member of your immediate family ever suffered from:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Hernia	<input type="checkbox"/> Backaches	<input type="checkbox"/> Headaches
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Numbness	<input type="checkbox"/> Sinus Trouble	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	

CURRENT CONDITION:

Please describe your condition and purpose for this visit: _____

Is this condition due to an injury or sickness arising out of Employment? No Yes

Is this condition due to an injury or sickness arising out of a Motor Vehicle Accident? No Yes

(if your condition is a result of an injury or sickness as indicated above, please inform the front desk)

Have you seen any other physician for this condition? No Yes

If Yes, Describe: _____

I certify that the above information is complete and true to the best of my knowledge. I understand that the information listed above will help assist the doctor in his/her evaluation of my condition.

Patient's Signature

Date

PLEASE CONTINUE ON BACK

PATIENT NAME:

INSURANCE INFORMATION: (if applicable) Please allow us to make a copy of your insurance card.

Insurance Company	Employer	Group#	Self Spouse Parent (Relationship to Patient)
Policy Holder Name	Policy Holder DOB	Policy Holder ID#	

ASSIGNMENT OF BENEFITS:

I am covered under a health insurance plan and request that Fulk Chiropractic Center submit health insurance claims on my behalf. I request that benefits be verified to establish an estimation of my Chiropractic benefits. I understand and agree that health or accident insurance benefits are subject to my eligibility and plan limitations. I further understand that I will be responsible for any deductible, co-pays/co-insurance, or any non-covered services.

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to **FULK CHIROPRACTIC CENTER** as payment for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payments.

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: c/o **FULK CHIROPRACTIC CENTER**
2110 E. SANTA FE
OLATHE, KS 66062

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patient or Insured Signature Date

Acknowledgement of Receipt of Privacy Notice

I acknowledge that Fulk Chiropractic will release Protected Health Information for the following reasons: to communicate with other healthcare professionals that are directly involved with my care, for purpose of reimbursement for services rendered and for the Practice to operate in accordance with applicable law and insurance requirements without an authorization from me. In accordance with the Health Insurance Portability and Accountability Act as described in the Privacy Notice which I received. I also understand that any questions I may have concerning the release of Protected Health Information can be discussed in detail with the Practice's Privacy Manager.

Patient or Insured Signature Date

CONSENT TO TREATMENT OF MINOR CHILD (if applicable):

I hereby authorize Dr. _____ and whomever he/she may designate as his assistants to administer treatment as he so deems necessary to my _____ (son, daughter), _____ (patient name).

Signature of Parent of Guardian Date