FULK CHIROPRACTIC

PATIENT INFORMATION

PLEASE PRINT

Full Name:_____ **Today's Date:**_____
(Last) (Middle) (First)

Address:_____**City:**_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

E-Mail Address:_____ **Sex:** □ Male □ Female **Birth Date:** ___/___/___ **Age:**____

Marital: M S W D **Social Security #:**_____-_____-_____ **Do you have children?** □Yes □No **How Many?**____ (if applicable)

Race/Ethnicity: □ American Indian □ Alaska Native □ Asian □ African American □ Hispanic or Latino

□ Native Hawaiian □ Other Pacific Islander □ White

Primary Language: □ English □ Spanish □ Other _____

How were you referred to our office? □ Patient Name _____ □Internet □Location

□PCP_____ □Insurance Co._____□Health Screening _____

□Heard one of our Doctors speak (where?)_____□Event _____

Employer:_____
Name Address City,State,Zip

Occupation:_____**Spouse/Parent (if patient is a minor):**_____

Spouse/Parent Social Security #:_____-_____-_____ **Spouse/Parent Birth Date:** ____/____/____ **Age:**_____

Spouse's Employer: _____
(Name) (Address) (City, State, Zip) (Phone)

Emergency Contact:_____ **Phone:** _____ **Relation to Patient:**_____

Current Condition: _____
Please describe the purpose for this visit

Have you seen any other physician for this condition? □ Yes □ No
If yes, please describe: _____

Is this condition a result of an accident? □ Yes □ No

PLEASE CONTINUE ON THE BACK

PATIENT INFORMATION PAGE 2

Patient Name:_____**Today's Date:**_____

Medical History:

Name of your Primary Care Physician:_____ Date of last physical:____/____/____

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 in the last year? □ Yes □ No
If yes, describe:_____

Have you ever suffered from:

□Dizziness	□Arthritis	□Digestive Disorders	□Hernia	□Backaches □Headaches
□Nervousness	□Neuritis	□Heart Trouble	□Numbness	□Sinus Trouble
□Rheumatic Fever	□Diabetes	□Asthma	□Anemia	□Cancer □High Blood Pressure

Which of the following most closely describes your smoking history?

□ Currently – Every Day □ Currently – Some Days □ Former Smoker □ Never Smoked

Current Medication List: (use back of page if needed)

	Medication Name	**Dosage**	**Type**
Example:	Lisinopril	10Mg	Oral Tablet
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Drug Allergies:_____

If you would like to be able to check your health records online, please let the front desk know.

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 evaluation of my condition.

_____ _____
Patient Signature (Parent if minor) Date

FINANCIAL/HIPPA INFORMATION
Fulk Chiropractic, P.A.

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Medicare □ Auto Accident □ Workman's Comp □ Other

Insurance Information: Please allow us to make a copy of your insurance card.

Insurance Co. Name:_____ Policyholder Name _____

Relationship to Patient Policyholder DOB: ____/____/____ Policyholder ID#_____
□ Self □ Spouse □ Parent

Employer _____ Group#_____

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

Consent to treatment of minor child (if applicable):

I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to administer treatment to my □son □daughter_____(patient name).

_____ _____
Signature of Parent of Guardian 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