Confidential Patient Information

DATE

HOW DID YOU COME TO THIS CLINIC? WHO REFERRED YOU? _____

IS YOUR VISIT DUE TO AN ACCIDENT? ☐YES ☐NO (IF YES, PLEASE COMPLETE THIS AND THE ACCIDENTAL INJURY REPORT)

PATIENT INFORMATION

NAME_____ HOME PHONE _____ WORK PHONE_____

CELL PHONE _____ EMAIL ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTHDATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ DRIVER'S LIC. # _____ SS# _____

EMPLOYER _____ EMPLOYER ADDRESS _____

SPOUSE _____ OCCUPATION _____ WORK PHONE _____

EMPLOYER _____ EMPLOYER ADDRESS _____

NAME OF EMERGENCY CONTACT _____ PHONE _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION _____

MEDICAL HISTORY **(If any of the following are relevant to your medical history, please check the accompanying box.)**

☐CANCER	☐MUSCULAR DYSTROPHY	☐RHEUMATIC FEVER
☐POLIO	☐MULTIPLE SCLEROSIS	☐SCARLET FEVER
☐TUBERCULOSIS	☐CONVULSIONS	☐NERVOUSNESS
☐HIGH BLOOD PRESSURE	☐EPILEPSY	☐ASTHMA
☐HEART TROUBLE	☐CONCUSSION	☐DIGESTIVE DISORDERS
☐DIABETES	☐DIZZINESS	☐SINUS TROUBLE
☐HEPATITIS	☐ARTHRITIS	☐BACKACHES
☐GERMAN MEASLES	☐NEURITIS	☐NUMBNESS
☐VENEREAL DISEASE	☐RHEUMATISM	☐ANEMIA

DESCRIBE ANY OPERATIONS YOU HAVE HAD _____ WHEN? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐YES ☐NO

DESCRIBE CONDITION _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐YES ☐NO WHAT KIND? _____

ARE YOU TAKING ANY MEDICATION? ☐YES ☐NO WHAT KIND? _____

IF FEMALE, ARE YOU PREGNANT? ☐YES ☐NO DATE OF LAST MENSTRUAL PERIOD? _____

INSURANCE DATA **(Clinic policy requires payment arrangements be made on the first visit)**

NAME OF PARTY RESPONSIBLE FOR PAYMENT _____ PHONE (_____) _____

DO YOU HAVE INSURANCE? ☐YES ☐NO COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE _____ SPOUSE'S INSURANCE _____

WORKER'S COMPENSATION _____ CLAIM NUMBER, IF OPEN _____

OTHERS _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon 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 to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE OR GUARDIAN'S SIGNATURE _____ DATE _____

If yours is an accident/injury, please complete the Accidental Injury Report as well

Gilroy Health & Wellness Center
Robert W. Kovacs, D.C.
7888 Wren Ave Ste. B-123
Gilroy, CA 95020

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Chiropractor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Chiropractor's attention, it is your responsibility to inform the Chiropractor.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Robert Kovacs, DC, to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other chiropractors and/or office staff members and is intended to include radiographic examination at the chiropractor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

Dated: _____

_____ _____

Patient's Name **Patient's Signature**

_____ _____

Parent or Guardian's Name (if a minor) **Signature of Parent or Guardian (if a minor)**

Gilroy Chiropractic Center
7888 Wren Ave, Ste B-123
Gilroy, CA 95020
(408)848-3666

HIPAA Privacy Practices Consent

Name of Patient: _____

Date of Birth: _____

I acknowledge that I have read and understand the Gilroy Chiropractic Center HIPAA Notice of Privacy Practices and have received a written copy if requested. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

_____ _____
Signature **Date**

If not signed by patient, indicate authority to act for patient: _____

FOR OFFICE USE ONLY

COMPLETE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient or patient's authorized representative because:

_____ Individual refused to sign
_____ Other (please describe) _____

_____ _____
Signature Date