FOX CHIROPRACTIC CENTER
(630) 232-6321

Patient Name: _____ Birthdate: _____ Sex: M/F Today's Date: _____

Address: _____City:_____ State: _____ Zip: _____

Home #: _____Email Address: _____ Cell #: _____

Would you like appointment reminders sent via: Email Text Cell Carrier (for text reminders): _____

Employer/ Occupation: _____ Work #:_____

Referred By: Patient Insurance Relative Other, _____

Person to contact in case of emergency: _____ Relationship: _____

Cell Phone: _____Regular Medical Doctor: _____

Billing Method: (Circle One)
Major Medical Insurance *Personal Injury* *Workers Compensation* *Cash*
Primary insurance goes through: Employer Spouse Self

Family History:	Back	Heart	Stroke	Cancer	Diabetes	High BP	Arthritis	Thyroid	Osteoporosis	High Cholesterol	Good Health	Unknown	Other
Mother:													
Father:													
No. of Sisters ___													
No. of Brothers ___													
No. of Children ___													

Social History:	Daily	3X/Week	2X/Week	1X/Week	2X/Month	1X/Month	Never
Standing:							
Sit at a Desk:							
Work on a Computer:							
Work on a Phone:							
Moderate/Heavy Labor:							
Stay at Home:							
Deliver Packages:							
Tobacco/Smoke:							
Alcoholic Beverages:							
Caffeine:							
Exercise:							

Surgical History: _____ Date Performed: _____
_____ Date Performed: _____
_____ Date Performed: _____

Smoking Status: (Please Circle) *Daily* *Occasionally* *Never* *Former* *Exposed to Second Hand*

Height: _____ Weight: _____BP: _____HR: _____
Allergies: _____
Medications & Supplements**:** _____
_____

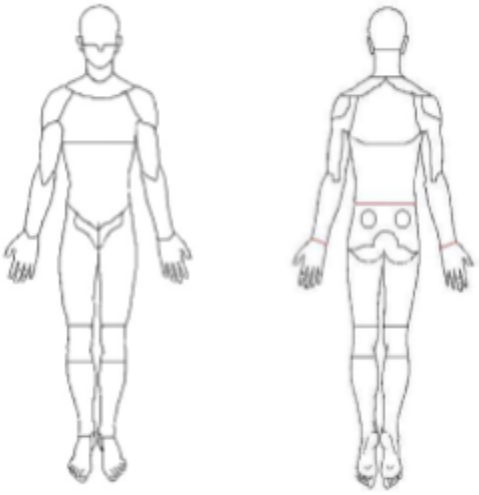
Implants, Rod, Screws, Pacemaker, Defibrillator, Ports_____

Health History: Please check all that apply to you:

__ADHD
__Alcohol/Drug Addiction
__Anemia
__Aortic aneurysm
__Arrhythmia
__Arthritis
__Asthma
__Back Pain/Joint Pain
__Bleeding Disorder
__Blood Clots
__Blood Transfusion
__Blurred Vision
__Bowel Problems
__Broken Bones
__Cancer
__Carpal Tunnel
__Cataracts
__Chickenpox
__Colitis
__Collagen Vascular Disease
__Constipation
__Depression/Anxiety
__Diabetes
__Digestive Disorders
__Dizziness/Fainting
__Eating Disorder
__Emphysema
__Epilepsy/Seizures
__Fatigue
__Female Health Challenges
__Fibromyalgia
__Gallbladder Disease
__Glaucoma
__Gluten Intolerance
__Gout
__Headaches/Migraines
__Hearing Loss
__Heart disease/ Attacks
__Heart Murmur
__Hemorrhoids
__Hepatitis
__High blood pressure
__High Cholesterol
__HIV/AIDS
__ Kidney Infections/ Stones
__Liver Disease/ Problems
__Lung Disease
__Menstrual Cramps
__Mental Disorder
__Neck pain
__Nervousness
__Night Sweats
__Osteoporosis
__Pneumonia
__Polio
__Paralysis
__Prostate problems
__Rheumatic Fever
__Scoliosis
__Sexual Dysfunction
__Sickle Cell
__Sinus Trouble
__Stress/Tension
__Stroke
__Suicidal Tendencies
__Thyroid Disease/ Problems
__Tuberculosis
__Tumor/growth
__Ulcer/Reflux
__ Urine Discoloration
__ Vertigo

Are you currently pregnant? (Please Circle): *Yes* or *No*

Please Mark with an "X" on the picture below where your pain/discomfort is currently



Type of Pain:

___Aching ___Burning ___Sharp ___Dull
___Radiating ___Stiff ___Stabbing ___Sore ___Tight
___Sharp ___Numbness ___Cramping ___Throbbing
___ Pounding
___Constricting ___Shooting ___Tingling

Is your pain/discomfort primarily on one side?

___ Right
___ Left
___ Bilateral

On a scale of 1-10, 10 being most intense, what would you rate your pain?

___ /10

Is your discomfort/ pain?
€ Mild € Moderate € Severe

_____
_____

DATE PROBLEM BEGAN: _____

HOW PROBLEM BEGAN: (please explain)

€ Gradually € Sudden € Overtime € Other

_____
_____

Have you seen anyone else for this condition? If yes, describe:

_____
_____

Have you had spinal X-Rays, MRI, CT scan? _____ Approximate date: _____

How often are your symptoms present?_____0-25% _____26-50% _____51-75% _____76-100%

Can you perform your daily activities? If No, describe: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of notice may change, if so, you will be notified at your next visit to update Your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do. We shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information, payment and healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:
Protected health information may be disclosed or used for treatment, payment or healthcare operations.
The practice reserves the right to change the privacy as allowed by law.
The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? YES NO
May we leave a voicemail message on your home or cell phone? YES NO
May we discuss your medical condition with a member of your family? YES NO
If YES, please name the member allowed and cell number:
_____

Signature:_____Date:_____

Witness: _____Date:_____

Annual Financial Policy

Thank you for choosing Fox Chiropractic Center for your Chiropractic Care. We are committed to providing you excellent care.

Group Health/Liability Insurance

- **It is the patient's responsibility to provide us with current/accurate policy** information when using a health insurance carrier. As a courtesy we will bill your insurance within 10 days of treatment.
- Patient copays or any out of pocket expenses, including account balances (if any) should be paid at the time of your visit.
- Our office will, nor cannot, guarantee your insurance will pay for your services. **If your insurance claim is denied or if a service is denied or not covered, you will be responsible for your charges in full**. It should be noted your benefits are a contract between you and your insurance company and this office only serves as an intermediary. We will at no time enter into a dispute with your insurance carrier over your claim. This is your responsibility and obligation.
- Workers compensation, personal injury, and/or managed care may take additional time to process and the charges may accrue over time. In some instances there may be limitations on your policy and if you elect to continue treatment, under these provisions you will be solely responsible for the balance.
- **Most insurance does not cover acupuncture, massage and some other services. It is your responsibility to know what is covered by your insurance. You will be responsible for what they do not cover.**

- I hereby authorize any payment of benefits made directly to Fox Chiropractic Center. Additionally, I authorize the release of any medical information necessary to process the claims.

Cash Patient: Self Pay*:*

- Payment for Cash claims must be made at the time of service. Once entered into a cash agreement Fox Chiropractic will not, under any circumstance, bill any previous cash charges to another party or insurance company. Please review and understand our cash policy pricing with the front desk.
- I hereby authorize Fox Chiropractic to bill me directly for any services received at their facility. I understand I am responsible for payment of those services at the time of my appointment.

Print Name: _____Date_____

Patient/Guardian Signature:_____