

Edinboro Family Chiropractic
Dr. John Amy

12650 Edinboro Road
Edinboro, PA 16412
(814) 734-4541
(814) 734-5562

CONFIDENTIAL PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____ Birth Date: _____

Home Phone: _____ Cell Phone: _____ Social Security # _____

Email: _____ **Would like us to add you to our e-mail newsletter? Y / N**

Do you have an Advanced Health Care Directive? Circle one - YES / NO

If yes – you will need to immediately provide us with a copy to keep in your permanent record as per Pennsylvania ACT 169

Student: Y / N **Sex:** M / F **Marital Status:** Single – Married – Widowed – Divorced – Separated

Employer _____ **Occupation** _____

Employer address _____ **Work Phone:** _____

Emergency Contact _____ **Relationship:** _____

Home Phone: _____ **Cell phone:** _____

Address _____

Who may we thank for referring you to our office? _____

May we have your permission to send a thank you letter? YES / NO

HISTORY OF INJURY

Describe your major complaint _____

Date when did this episode began _____ **Is it Work or Auto Related?** _____

Have you lost work due to the injury? YES / NO If so, dates _____

Have you seen a Physician for the present complaint? YES / NO Who & When _____

Did the Physician have any X-rays/MRI/Cat Scan taken? YES / NO Where _____

Please Rate the Severity of your problem – Occasional – Mild – Moderate – Severe

PAST MEDICAL HISTORY

Previous Operations _____

_____ **Serious Illnesses** _____

Hospitalizations _____

When: _____ **Name of Hospital** _____

Turn Over→

Who is your Family Physician _____

Are you under a Doctors Care at this time? _____ For _____

List any medications, vitamins or supplements you are taking _____

Do you have any allergies? _____

Last Physical Exam _____ Height _____ Weight _____

Have you ever had Chiropractic Care? _____ Who & When _____

Have you ever had Massage Therapy? _____ Who & When _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this bill? _____

Do you have any type of Health Insurance – including Health Savings Accounts, AFLAC, Etc.

If so, Name of Insurance _____

Please give us your Insurance Card to copy if we are submitting or request a receipt if you are submitting the Insurance.

INSURANCE AGREEMENT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Further more, I understand that the doctor's office as a courtesy to me will prepare any necessary report and form to assist me in making collection from the insurance company. Any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. 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 understand that I am responsible for any Deductibles and/or Co-Insurances, Co-pays and also if I have exhausted my yearly benefits I am responsible to payment by cash or check thereafter. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately and payable. I do hereby verify the above information as correct and understand the office policies as stated.

TREATMENT AUTHORIZATION

I also authorize and request the performance of chiropractic services for minor child, so designated above, or myself and give my consent of any advisable and necessary procedures to be administered by the attending physician or by his supervised staff for medical diagnosis purpose and treatments.

PRIVACY NOTICE

I have read and I understand Edinboro Family Chiropractic's Privacy Policy for Consent for Use or Disclosure of Health Information and Appointment Reminders and Health Care Information Authorization. I understand that I may receive a copy of these policies upon request at any time.

Patient (or guardian) signature _____

Date _____

FEMALES ONLY

Is there any possibility you are pregnant? _____ If so how many weeks? _____

Date of Last Menstrual Cycle _____

(Please mark none if you have gone through Menopause or write none due to birth control shots)