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_________ Cell Phone _____________________

Home Phone ____________________________ Work Phone_______________________________

Birth Date __________________ Age______ Social Security #_____________________

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

---

Employer_______________________________ Occupation_________________________

Employer address____

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_________________________

What 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)