

Please answer the following questions to the best of your ability. If you do not know the answer write "Don't Know", do not leave blank.

PERSONAL INFORMATION

Date: ___/___/___ Name _____ Address _____
City _____ State ___ Zip _____ SS# _____ - _____ - _____ Birthday: ___/___/___ Sex: M / F
Home Tel.# (____) _____ Work Tel. #(____) _____ Cell Phone # (____) _____
Email: _____ Marital Status: S or M Height: _____ Weight: _____
Employer name & address: _____
Occupation: _____ Job duties include: _____
Spouse's Name: _____ Spouse's work Tel.#: (____) _____
Spouse's employer's name & address _____
How did you hear about our office? Referred by PCP Insurance Booklet Friend _____
 Yellow Pages Website / Internet Other _____

YOUR HEALTH CONDITION

What is your major complaint? _____
When & how did it occur? _____
Other doctors seen for this condition: _____
Is your condition the result of an auto accident? **Y** or **N** Is your condition a work related injury? **Y** or **N**
Rate pain on a scale from 1-10 (Circle One, 10=Most Painful) **1 2 3 4 5 6 7 8 9 10**
Does the pain wake you up at night? **Y** or **N** Any excessive weight loss / gain? **Y** or **N** Any dizziness or fainting? **Y** or **N**
Does this interfere with your: Work? **Y** or **N** Sleep? **Y** or **N** Daily Routine? **Y** or **N** Recreation? **Y** or **N**

<p>Check those that best describe your condition:</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Numb <input type="checkbox"/> Burning <input type="checkbox"/> Sharp <input type="checkbox"/> Migraine <input type="checkbox"/> Shock-like <input type="checkbox"/> Achy <input type="checkbox"/> Cramping <input type="checkbox"/> Constant <input type="checkbox"/> Stiff <input type="checkbox"/> Knifelike <input type="checkbox"/> Comes & Goes</p>	<p>Your past medical history. Mark all that apply:</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart disease/Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney disease <input type="checkbox"/> HIV <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Spinal surgery</p>
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List any medication(s) you are currently taking: _____
Past medical or chiropractic treatment: _____
Describe any past surgery or broken bones: _____
Female Patients: Are you currently or do you have any reason to believe you are pregnant? **Y** or **N**

HEALTH INSURANCE INFORMATION

Insurance Name & Address: _____
Policy #: _____ Are you covered by Medicare? **Y N**
Secondary Insurance carrier: _____
Secondary Insurance Subscriber's Name: _____ Policy #: _____

Office Policies:

You the patient are responsible to check with your insurance company to verify Chiropractic coverage before treatment begins, i.e., if a referral is needed. Patients are responsible to obtain all referrals (if needed). If your policy requires a referral, you must present referral to front desk, before you are seen by the doctor. DO NOT expect your primary care physician to “back-date” your referral. If treatment is rendered and referral was not obtained/presented, you the patient will be responsible for payment.

Co-Payments are due at the time chiropractic services are rendered. Insurance companies forbid the waiving of deductibles or co-payments by healthcare providers. Co-Insurance must be paid in full.

ALL appointment cancellations must be confirmed within 24 hours of your scheduled time. Office charges for time reserved will apply for ANY appointments cancelled without proper notice.

I understand that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me and/or my attorney (if applicable, charges may apply) in making collection or settlement 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 irrevocably authorize, direct and instruct my attorney (if applicable) to make payment to Dr. Kovacs from my settlement, fees due, to his office as mandated within the PIP fee schedule. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

The purpose of requiring all new patients to attend a Special Consultation / Spinal Health Orientation Workshop is to enlighten you about your body, especially the spine and the nervous system. We have found that patients attending this class seem to respond faster because they can help us to help them. Proper health care is a two edged sword. Both the doctor and the patient have carious responsibilities.

Therefore you and your spouse or another family member are **required** to attend. If you have a friend or relative who may be contemplating whether or not chiropractic care may be a help to them, this is an excellent opportunity to find out about chiropractic. Just inform our receptionist to reserve a place for them.

Informed Consent:

Furthermore, I understand that if I am accepted as a patient at the Eatontown Elite Care Center, I am authorizing Dr. Kovacs to proceed with any standard treatment that may be necessary. Any risk involved regarding chiropractic treatment will be explained to me upon my request. I am aware it is the responsibility of the patient to make it known, or to learn through health care procedures, the existence of underlying conditions that would otherwise not come to the attention of the Chiropractic Physician. Conditions include, but are not limited to: latent pathological defects, illnesses or deformities.

I hereby attest all information given above is true to the best of my knowledge.

Patient’s Signature: _____ Date: _____

Guardian’s or Spouse’s Signature: _____ Soc. Sec. #: _____