

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

Name _____ Date: ___/___/___

If your contact information has not changed, skip to next section

Address _____ City _____ State _____ Zip _____

Home Tel.# (____) _____ Work Tel. #(____) _____ Cell Phone # (____) _____

Email: _____

YOUR HEALTH CONDITION

Reason for Visit: Routine Check-up Re-Agravation of Old Injury New Injury (Please Describe Below)

What is your major complaint? _____

When & how did it occur? _____

Other doctors seen for this condition: _____

Rate pain on a scale from 1-10 (Circle One, 10=Most Painful) 1 2 3 4 5 6 7 8 9 10

Since your last appointment, have you had any surgical procedures, fractures, or any traumatic injuries? **Y or N**

FEMALE PATIENTS ONLY

Are you currently or do you have any reason to believe you are pregnant? **Y N.**

HEALTH INSURANCE INFORMATION

If insurance information has not changed, skip this section

Insurance Name & Address: _____

Policy #: _____ . Are you covered by Medicare? **Y N.**

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.

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. #: _____