Patient Information

Legal First Name: ______________________ MI: ______ Last Name: ______________________________

Street: ____Apt: __________

City: ____ State: ________ Zip: _____________________

Social Security #:______________________ Marital Status: S M W D Spouse:____________________

Language: _____English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____ French _____ German _____ Russian _____ Other______________

Race: _____ White ____ _American Indian or Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander _____ Black or African American _____ Hispanic or Latino _____ Decline to Answer _____Other_______________

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

DOB: ____________ _____ Home Phone: ______________________ Work Phone:_______________

Cell Phone: _______ ____________________ Cell Carrier____________________________________

Please check your contact preference: _____Hm _____ Wk _____ Cell _____Email _____ Postal Mail

Email hm: ________________________________ Email wk: __________________________________

Emergency Contact:__ ______________________ Phone Number: ____________________________

Whom may we thank for referring you to our office? ____

Occupation: _______ ______________________ Employer: _____________________________________

Employer Address: ____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _______ ______________________ M.I. ________ Last Name: _______________________

Policy Holder's Date of Birth: ________________ Policy Holder's SS#: ____________________________

Policy Holder's Employer: ____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _______ ______________________ M.I. ________ Last Name: _______________________

Policy Holder's Date of Birth: ________________ Policy Holder's SS#: ____________________________

Policy Holder's Employer: ____

Patient History

Are you seeing anyone else for other problems or health conditions? ☐ Yes ☐ No

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

____

____

____

Past health history

Have you...	Yes	No	If yes, include date & provider seen
...been hospitalized in the last 5 years?	☐	☐	____________
...been diagnosed with Diabetes?	☐	☐	____________
Type I____or Type II_____			
...been treated for hypertension?	☐	☐	____________

Do you smoke? ☐Never ☐Former Smoker ☐Current/Every Day Smoker ☐Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by

Please be as specific as possible

____

____

____

____

____

Do you have allergies? ☐Food ☐Environmental ☐Medication

List Type of Allergy and Reaction

____

____

____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, 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 also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: ______________________________

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: ______________________________

HEALTH QUESTIONNAIRE

PLEASE CHECK ( ) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

MUSCULO-SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Muscle spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

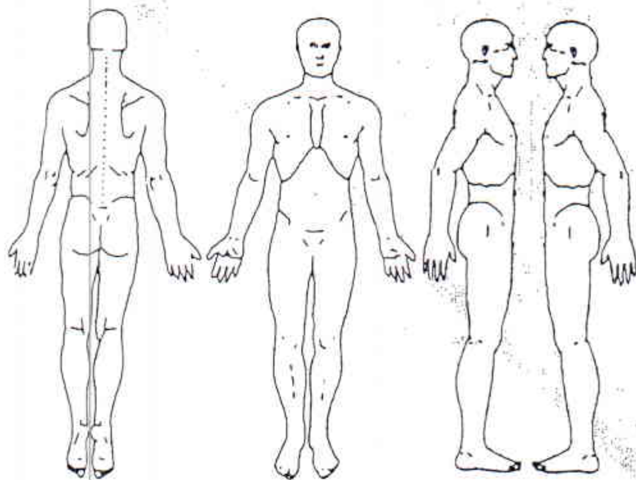
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

Please mark areas of pain on the figures below



P ___ Pain
N ___ Numb
H ___ Hypoesthesia
S ___ Spasm

Pain Index
Least 1 2 3 4 5 6 7 8 9 10 Most

GASTRO-INTESTINAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confustion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Excercise
- ❑ Drug Abuse
- ❑ ____________________

Patient's Signature ____________________

CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistant cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose viens

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

FOR OFFICE USE

____
____
____
____

Patient Accepted? ❑ Yes ❑ No   Doctor's Signature ____________________

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Authorization for the Use and Disclosure of Protected Health Information:

This authorization has been requested by Choy Chiropractic. The purpose of this authorization is to inform you about how your personal information may be used by Choy Chiropractic. Our clinic uses a variety of methods to communicate with our patients. To effectively provide our patients with proper "Secure and Private healthcare information" we may do any of the following in our daily operations.

- Call you at your listed phone numbers to confirm appointment times, leave messages, respond to your questions, return messages or to communicate about any clinical operations including billing, scheduling, finances or anything pertaining to your care. If you have a minor in our office or in the case of an emergency, we will try and contact you by whatever means you have listed in your file.
- Mail and/or email information to you any pertinent clinical operations that pertain to you.
- Use your name on a referral thank you board, and/or in a testimonial book.

If you choose NOT to authorize any of the above for any reason please strike through the words or the section that apply.

Please initial here ________________

Privacy Officer initial________________

Once agreed to, you have the right to revoke this authorization as you deem necessary. If you wish to revoke this authorization please do so I writing. Your care in this office will not be conditioned on you agreeing to this authorization. The information released under this authorization may be re-disclosed by the party receiving the information. We have no control over such re-disclosures.

__________________________________ ________________

Signature Date

____

Printed Name

If you are a minor or if another person represents you, please provide the appropriate person's:

__________________________________ ________________

Printed Name Date

Relationship to patient __________________________________

Unless otherwise indicated this authorization shall expire six (6) years from the date completed

FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:
Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

Payment Arrangements
We require that you pay 100% of your charges on a per visit basis. Your portion of the bill is expected to be paid by the 30th day of each month, and any unpaid balances will be considered past due on the first day of the following month. Past due balances may have an interest charge of 8% applied per month.

Assignment of Benefits
Attached is an "Assignment of Benefits" form which we would like you to sign. This form directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from the insurance.

Release of Information
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_______________________________ Signature

_______________ Date

ADVANCED HEALTH SOURCE

CHOY
CHIROPRACTIC

Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the chiropractic needs of other patients, please be courteous and call Choy Chiropractic promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please call 626-792-2932. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

Late Cancellations:

Late cancellations will be considered as a "no-show".

No-Show Policy

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-show" will result in a fee of $25.00 billed to the patient's account.