Welcome to Our Office

Patient Information

Date: _____

Patient Name: _____
Last name, First name

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: ☐ M ☐ F Age: _____ DOB:_____

Social Security #: _____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for ___years

Race:_____ Ethnicity:_____

Primary Language:_____

Occupation:_____

Patient Employer/School: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Primary Care Provider:_____

In case of Emergency, contact:

Name: _____ Phone: _____

How did you hear about our office: _____

_____

Communication Preferences

We will contact you the day before your appointment and if you miss any appointments. Would you like to receive reminders via:

☐Text messaging ☐Email ☐Both

Make sure to read and accept our welcome email.

Do you give the practice consent to call your home/cell phone with automated reminders and other information regarding your care?

☐Yes ☐No

Contact preference: ☐Home ☐Cell

Accident Information

Is this condition due to an accident? ☐Yes ☐No
Date: _____
Type of Accident: ☐Auto ☐Work ☐Other

To whom have you made a report of your accident?
☐Auto Insurance ☐Employer ☐Workers Comp ☐Other
Attorney Name: _____

Insurance

Health Insurance Company: _____
Who is the primary insured?_____
Relationship to patient: _____
Policy #: _____
Group #: _____
Is patient covered by secondary insurance? ☐Yes ☐No
Health Insurance Company:_____
Who is the primary insured?_____
Relationship to patient: _____
Policy #: _____
Group #: _____

Financial Policy

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to ☐HealthFirst ☐Kurtz Chiropractic and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify the previously listed party of any changes to my health care coverage. In some cases, exact insurance benefits can not be determined until the insurance company receives claims. I am responsible for the entire bill or balance of the bill as determined by the clinic and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to ☐HealthFirst ☐Kurtz Chiropractic for all covered medical services and supplies provided by the previously listed party and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by the clinic, and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the previously listed party of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me.

The clinic may use my health care information and may disclose such information to the listed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Print Name of Patient, Guardian, or Personal Representative

_____
Signature of Patient, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

Welcome to Our Office

HIPAA Privacy and Release of Information Authorization

Patient Name:

Patient DOB:

I, _____ hereby authorize ☐HealthFirst ☐Kurtz Chiropractic and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient Printed Name Date

_____

Patient Signature

Whom would you like to add to your account that we could talk to about your care? (spouse, child, sibling)

_____

Welcome to Our Office

Missed Appointment Policy

Cancellation of an Appointment:
In order to be respectful of the medical needs of other patients, please be courteous and call our facility if you are unable to attend an appointment. This time will be reallocated to someone in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours prior to your allotted appointment time, you will be charged a $15.00 missed appointment fee.

How to Cancel Your Appointment:
To cancel your appointment, please call (252) 293-1010. If you do not reach the receptionist, you may leave a detailed message with our after-hours call center which is available to you 24/7. 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.

Patient
Signature:_____Date:_____

Staff Signature:_____Date:_____

Welcome to Our Office

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

FAVORITE PHARMACY _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date:_____	Meningococcus	Date:_____
Flu Shot	Date:_____	MMR *(Measles, Mumps, Rubella)*	Date:_____
Gardasil/HPV	Date:_____	Pneumonia	Date:_____
Hepatitis A	Date:_____	Tdap *(Tetanus and pertussis)*	Date:_____
Hepatitis B	Date:_____	Tetanus	Date:_____
		Zostavax *(Shingles)*	Date:_____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

PAST MEDICAL HISTORY

Welcome to Our Office

Please circle all that apply:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes - Insulin	High Cholesterol	Stroke
Diabetes - Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Father	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Mother	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Other:_____	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke

SOCIAL HISTORY

Education Less than 8th grade
High school
2 year college 4 year college
Post graduate

Marital Status Married Single
Divorced Separated Widowed
Domestic partner

Exercise Level None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Caffeine None Occasional
Moderate Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
Yes No
If so, how often?
Occasionally < 3 times a week
> 3 times a week

Tobacco , Do you use tobacco?
Yes No
If not currently, did you ever use tobacco? Yes No
Cigarettes -____pks./day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:

GYN HISTORY (WOMEN ONLY)

Last Menstrual Period:_____
Last Pap Smear:_____
Are periods regular? Yes No

Age at Menopause:_____
Total Pregnancies:_____
Full Term Pregnancies:_____

Miscarriages:_____
Abortions:_____
Preterm Pregnancies:_____

Please add any other information about your health that you would like your provider to know here: