PATIENT INFORMATION & CONDITION FORM

Patient Name: ____ Today's Date: ___/___/___

Social Security Number (opt) ____________________ Birth Date: ___/___/___ Age: ____

Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father/Mother: ______________________________

Phone: (_____) _____________

Guardian: ______________________________

Phone: (_____) _____________

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? __________

CURRENT ADDRESS

Street____

City ____ State ____ Zip _____________

Phone (______) _______________

Your Occupation __________________________ Employer ____________________

Work Address ____________________________ Work Phone (_____) _______________

Student at ______________________________

☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? ______________________________

Phone (_____) _____________

How did you learn about us?____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Where and how did the accident occur?

____

____

Approximately, when did your injury or condition occur? ___/___/____

Describe your condition, symptoms, or the purpose of this appointment:

____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe:

____

____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: ______________________ Type of Doctor: __________________________

Date of Last Visit: ___/___/____

What surgery have you had? ____

When? _________________

Serious illnesses or conditions? ____

When? _________________

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: ____

What medications or drugs are you taking? ____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: ____

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney's who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: ____ Date: ___/___/____

Financial Policy

Our fees have been established with the understanding that our services are a valuable asset to the community and should be as affordable as possible. We are committed to providing our services at reasonable costs that match or remain less than “ national average” health care costs specific to cash based practices using chiropractic and applied kinesiology procedures. Each patient is responsible to pay for services rendered at the time of the visit. Outstanding balances of more than $200 will prevent further treatment by Kenny Chiropractic until 90% of that balance is paid off or the patient has a prior agreement with KennyChiropractic for repayment.

We understand financial hardship and extenuating circumstances may prevent an individual from seeking appropriate medical care. KennyChiropractic can be sensitive to those in our community having special needs, but it is to our discretion as to how much grace is applied per individual situation. In the event Kenny Chiropractic perceives the patient is taking advantage of the time and resources made available to patients, services will be discontinued until fiduciary responsibility has been corrected.

By signing this form, the patient (the individual receiving therapeutic services from Kenny Chiropractic) agrees to the financial policies presented herein (paid in full at time of service or payment plan arrangement for special cases). If the patient has any questions or concerns about our policies, they should contact Dr. Kenny directly, either by personal consultation, email, or personal phone conversation.

____________________________________ __________________________________
Patient’s Name: (please print) Patient’s Signature

____
Date