IRVINE CHIROPRACTIC CENTER

If you need any assistance completing the paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful and educational.

Patient Contact

Name____ Date________________

Address____

City______________________________ State_______ Zip___________________

Phone: Hm______________ Wk__________________ Cell__________________

Email Address____

Date of Birth_______________ Age________________ Sex_________________

Marital Status: M S W D Number of Children________________________

Employer______________________ Occupation______________________________

Who Referred You To Our Office?____________________________________

Insurance Information

Name of Insurance
Company____ PPO HMO EPO
Is your condition due to an accident or illness?______________________
Did your accident occur while at work?_____________________________
Were you involved in an automobile accident?_________________________

X-Rays

Have you ever had x-rays before? Yes No When______________________
What areas were x-rayed____

Women Only

X-rays are contraindicated during pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know.
Are you pregnant? Yes No
When was the onset of your last menstrual cycle?______________________

Current Health Condition

Purpose of today's appointment______________________________________

____

Please indicate on the diagrams below your areas of pain and discomfort:

How long have been experiencing your primary complaint?________________

Is your pain: (please circle)
Dull Achy Sharp Numb Tingling Burning Throbbing

Does your pain radiate down your legs or arms?
If yes, please describe____

Do you know what caused your current condition?
If yes, please describe____

Is the pain: (please circle) Constant Frequent Intermittent Occassional

What makes the pain feel better?____

What makes the pain feel worse?____

Use the scale below to rate the pain of your primary complaint.

0 1 2 3 4 5 6 7 8 9 10

No Pain Intermediate Pain Worst Pain

____

Accidents, Injuries or Surgeries

List any auto accidents that you have been involved in, begin with the most recent:

____

____

List any job related injuries that you have experienced, begin with the most recent:

____

____

List any sports injuries that you have experienced, begin with the most recent:

____

____

Have you had any hospitalizations or surgeries? If so state when and what for:

____

____

Medications

Are you taking any medications (prescription & over-the-counter)? Yes No
If yes, please explain the reason:____________________________________

____

Do you have any of the following conditions?

___ Contagious Diseases
___ Infection
___ Fever
___ Flu or Cold
___ Diabetes
___ Cancer
___ Skin Problems
___ Kidney Disease
___ Smoker, How many per day ____

___ Circulatory Problems
___ Stroke/ Heart Disease
___ High Blood Pressure
___ Low Blood Pressure
___ Varicose Veins
___ Lung Disease
___ Allergies (including oils/creams) __________

___ Arthritis
___ Headaches
___ Muscle Spasms
___ Inflammation
___ Epilepsy/Seizure
___ Pinched Nerve

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. The law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, your file may be reviewed by a specialist doctor whom we may involve your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your health insurance company. We may disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about an appointment. If you are not home, we may leave this information on your answering machine or with a person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the normal uses. As we need to contact you from time to time, we will use whatever address or phone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge a reasonable fee for the copy.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we still will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change the details of this notice, we will notify you of the changes in writing. Questions or complaints about this Notice of Privacy Practices, or how this practice handles your health information, should be directed to our privacy officer, Jean Roberts.

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of the Notice of Privacy Practices.

Signed______________________________ Print Name_________________________ Date___________

Dr. Kevin Kroes, D.C.
18017 Sky Park Cr. Ste. F., Irvine, Ca. 92614
Phone (949) 862-7499

Informed Consent Form

Dear Patient,

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Consent to Treatment

The following points have been explained to me to my satisfaction, and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

1. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.

2. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic health care is no different.

3. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which he/she feels at the time to be in my best interest.

4. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.

5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. However, we will give you our best care.

6. I understand that there are other forms of treatment, including drugs and surgery, which could be options for my condition, but at this time, I choose chiropractic care.

I have read the above consent, or it has been read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

Patient Signature ______________________ Date ______________

Benefits Assignment

I authorize that payment of charges be made directly to the doctor of this clinic. This authorization includes:

1) All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy.
2) Amounts owed on my behalf from proceeds of any settlement related to my case.
3) I authorize the release of any necessary information to my insurance company, pre-paid health plan or account, or government, managed health plan to request payment benefits to me or my assignee.
4) I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature:_________________________________**Date**______________