CONFIDENTIAL PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____
WHO REFERRED YOU?

Name _____ Male ___ Female ___ Phone _____

Address _____ City_____ State _____ Zip _____

Age _____ Birthdate _____ Marital: M S W D Children # _____

Occupation _____ Employer _____ Phone _____

Address _____ City_____ State _____ Zip _____

Cell Phone _____ Name of Wife, Husband or Guardian _____

Email Address _____

Are you HIV Positive? _____ Hepatitis B/C _____

By signing below, I acknowledge that I have read the four HIPAA regarding Redisclosure, Fund Raising, Marketing and Appointment Reminders and Right to Complain.

I understand and agree that health and accident insurance policies are an arrangement between the carrier and myself. Furthermore, I understand that Steven P. Kuhn, D.C. 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 Steven P. Kuhn, D.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 for professional services rendered me will be immediately due and payable.

Authorization For Treatment

I, _____, authorize the performance upon myself of the following procedures: Chiropractic manipulations, hot/cold packs, electrical muscle stimulation and ultrasound to be performed by or under the direction of Steven P. Kuhn, D.C.

I also consent to the performance of other diagnostic and therapeutic procedures, in addition to or different from those stated above whether or not arising from presently unforeseen conditions that the above named doctor, associate or assistance, may consider necessary or advisable in the course of my health care.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequence, and the possibility of complications have been explained to me by the above named doctor and/or his associates and assistants.

I acknowledge that no guarantee or assurance of the results may be obtained from the procedure has been given by the above named doctor, his associates or assistants.

PAYMENT IS EXPECTED AT TIME OF SERVICE. Patients choosing to bill their insurance company must understand that if the insurance does not pay, they will be billed and responsible for the services at the billed rate. Time of service patients that pay on the day services, pay the time of service price.

Date: _____ **Signature:** _____

SS: _____

Patient's Signature _____ **SS#** _____

IF THIS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE.

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident _____ Hour _____ AM _____ PM _____
Location _____
How did accident occur? Auto Collision _____ On-the-job _____ Other _____
If not an auto collision, please describe the circumstances: _____
_____
_____
Did you report the injury to your foreman or employer? Yes _____ No _____
Did he (they) recommend care at our office? Yes _____ No _____
If Auto accident, were you the: Driver _____ Passenger _____ Pedestrian _____
If Auto accident, were you struck from: Behind _____ Right Side _____ Left Side _____ Front _____ Parked _____
Did your car strike the other (s) involved? Yes _____ No _____
Did the other car strike yours? Yes _____ No _____
Were you sitting in the _____ Front or _____ Back seat of the auto?
Auto was carrying _____ people. Were you seat belted? Yes _____ No _____
Immediately following the accident you went:
Home _____ To the hospital _____ To another doctor's office _____ To this office _____
To Work _____
As a result of the accident were traffic citations issued to you? Yes _____ No _____
To the driver of the other car? Yes _____ No _____ Don't Know _____
List the extent of the injuries, as you know them: _____
_____
_____

Did you require Post-Accident Hospitalization? Yes ____ No ____ Emergency Room Only _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

_____ Headache	_____ Pins & Needles in Arms	_____ Buzzing in Ears
_____ Neck Pain	_____ Pins & Needles in Legs	_____ Loss of Balance
_____ Neck Stiffness	_____ Numbness in Fingers	_____ Fainting
_____ Sleeping Problems	_____ Numbness in Toes	_____ Loss of Smell
_____ Back Pain	_____ Shortness of Breath	_____ Loss of Taste
_____ Nervousness	_____ Fatigue	_____ Diarrhea
_____ Tension	_____ Depression	_____ Feet Cold
_____ Irritability	_____ Lights bother eyes	_____ Hands Cold
_____ Chest Pain	_____ Loss of Memory	_____ Stomach Upset
_____ Dizziness	_____ Ears Ring	_____ Constipation
_____ Head Seems Too Heavy	_____ Face Flushed	_____ Cold Sweats
_____ Hurts to Swallow	_____ Fever	_____ Other

Symptoms other than above: _____
Have you lost any days of work? Yes _____ No _____ Dates: _____
Insurance Companies Involved:
My Company _____
Company of Person Responsible for Injuries _____
Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim?
Yes _____ No _____