Confidential Patient Health Record

DATE: _____ I.D. #: _____

PERSONAL HISTORY

Last Name: _____ **First Name:** _____ **Middle Initial:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone: (_____)_____ **Cell Phone: (_____)**_____ **Email** _____
Birth Date: _____ **Age:** _____ **Sex:** ☐ *M* ☐ *F*
Social Security #: _____ **Circle One:** *Married Single Widowed Divorced Separated*
Employer: _____ **Type of Work:** _____
Work Address: _____ **Work Phone:** (_____)_____
Name of Spouse: _____ **Spouse's Employer:** _____
Spouse's Work Phone: (_____)_____ **Type of Work:** _____
Name & Ages of Children: _____
Name and Number of Emergency Contact: _____ **Relationship:** _____
Who is responsible for Your Bill? ☐ *You* ☐ *Spouse* ☐ *Workers' Comp.* ☐ *Auto Insurance* ☐ *Medicare* ☐ *Medicaid*
☐ *Personal Health Insurance (Name)*: _____ *Policy #*:_____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____
Other Doctors Seen For This Condition?: ☐ *Yes* ☐ *No* **Who?** _____
Type of Treatment: _____ **Results**: _____
When did this condition begin? _____ **Has This Condition Occurred Before?** ☐ *Yes* ☐ *No*
Is this condition: ☐ *Job Related* ☐ *Auto Accident* ☐ *Home Injury* ☐ *Fall* ☐ *Other:* _____
Date of Accident: _____**Time of Accident:** _____
Have You Made a Report of Your Accident to Your Employer? ☐ *Yes* ☐ *No*
Drugs You Now Take: ☐ *Nerve Pills* ☐ *Pain Killers* ☐ *Blood Pressure Medicine* ☐ *Insulin* ☐ *Other:* _____
Do you wear a shoe lift? ☐ *Yes* ☐ *No*
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____
_____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: ☐ *Appendectomy* ☐ *Tonsillectomy* ☐ *Gall Bladder* ☐ *Hernia* ☐ *Back Surgery*
☐ *Other:* _____
Broken Bones: ☐ *Yes* ☐ *No* **If yes, please list:** _____
Major Accident or Falls: _____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: ☐ *No* ☐ *Yes* ☐ Doctor's Name & Approximate Date of Last Visit:_____
_____
Check Any Of The Following That Apply:
INTAKE: ☐ *Coffee* ☐ *Tea* ☐ *Alcohol* ☐ *Cigarettes* ☐ *White Sugar*

FEMALES ONLY: When was your last period? _____ Are you pregnant? ☐ *Yes* ☐ *No* ☐ *Not Sure*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I understand that my insurance company or administrator may deem the services and procedures I receive as not medically necessary. It may not be possible to determine what fees and procedures will be considered medically necessary until some significant time past what Dr. Zilahy considers timely treatment, therefore, I agree to treated as recommended and I will be responsible for payment of those services not covered.

Regarding x-rays, it is understood and agreed the amount paid the Doctor, is for examination and x-rays. The X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Our goal is to provide high quality care at a reasonable cost to our patients. In fairness to other patients, and the doctor, we require at least 4 hours notice when canceling an appointment. There is a $10 fee for missed appointments without a 4-hour notification, which will be due and payable from you. The practice reserves the right to dismiss patients with excessive cancelled appointments.

Patient's Signature _____ **Date**_____

Guardian or Spouse's Signature of Authorizing Care _____ **Date**_____