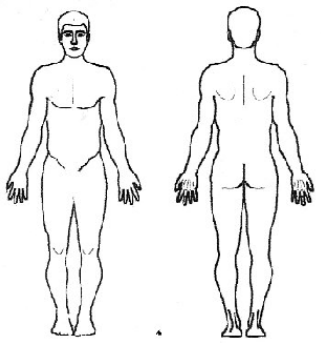
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

THREE KINGS CHIROPRACTIC
guiding others to a healthier life

Additional Patient Information

Patient Information:

Patient Preferred Name:

Phone #'s:

Home: Cell:

Work: May we text you appointment reminders? Yes No

Email:

Marital Status:

Referred By:

Chiropractic Provider: ***Three Kings Chiropractic LLC***

Employment Information:

Status: Employed Full time student Part time student Retired Unemployed

Occupation:

Employer/School:

Address of employer/school:

Insurance Information:

Patient Relationship to Primary Insured: Self Child Spouse Other

Primary Insured Name:

Primary Insured Birthdate:

Primary Insured Gender:

Primary Insured Employer:

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Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders and information and understand that…
I may be contacted by: phone at home or work, mobile phone, e-mail or postal mail.
Messages may be left: on answering machine, voicemail at home, work, and on mobile phone, or with individuals answering my phone at home or work.
Also: TKC may send personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders, correspondence letters pertaining to my care. *Please place a line through any method you REFUSE to, and place your initials there.*

Information that we use or disclose based on this authorization may be subject to re-disclose by anyone that has access to the reminder or information and may no longer be protected by the federal privacy rules.
You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.
You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).
I authorize the use or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Rep. (TKC)

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THREE KINGS CHIROPRACTIC
guiding others to a healthier life

Payment Policy

We strive to provide the highest quality healthcare while maintaining affordability. We unfortunately do not accept assignment from all insurance companies. If you have any questions or concerns please feel free to ask.

Please initial:

_____ **Full payment at time of service**. Cash, VISA, MasterCard, Discover and/or check accepted.

As a courtesy, TKC will submit your receipt to your insurance company for reimbursement or application to any deductible. This is NOT a superbill for Medicare!

_____ **Bill to Cigna** *Co-payment due at time of service.* **(DR YASER ONLY)**

_____ **Bill to Blue Cross/Blue Shield** *Co-payment due at time of service.* **(DR YASER ONLY)**

I have read, understand and agree to the payment policy of Three Kings Chiropractic. I understand that I am responsible for all costs of my chiropractic care and have selected the payment plan initialed above I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand all balances are due when services are rendered. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.

Print Patient Name: _____

Guardian name: _____

Patient or Guardian's Signature_____

Date_____

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I understand and agree that health insurance policies are an arrangement between an insurance carrier and me. 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 the Doctor' s office will be credited to my account upon 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 care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature_____
Date:_____

Consent to treat a Minor _____
Date:_____

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

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Patient Name: _____

Please list all Medications you are currently taking:

_____

_____

_____

_____

_____

Please list all surgeries you have undergone:

_____

_____

_____

_____

_____

Please list all Health Conditions you currently have:

_____

_____

_____

_____

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guiding others to a healthier life

Patient Name: _____

In an effort for better communication among health care providers TKC would like to let your primary medical doctor know that you are receiving treatment here and inform them of your treatment plan. Please list the name(s) of your primary and specialist medical doctors:

Primary name and number:

_____

_____

_____

_____

_____

Specialists name and number:

_____

_____

_____

_____

_____

Patient Signature: _____

Date: _____

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