Please place a check mark in the appropriate box to indicate the office that you are now at.

Kozik Chiropractic
1055 East Main Street
Corry, PA 16407
814.664.2216
☐

Kozik Chiropractic
8800 Perry Highway
Erie, PA 16509
814.864.8300
☐

PATIENT HEALTH INFORMATION

PATIENT FULL NAME: _____DATE: ____/____/_____
First Middle Last

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

E-mail address: _____ Number of Children: _____

Home Telephone Number: _____ Work Telephone Number: _____

Employer's Name: _____ Occupation: _____

Date Of Birth: ____ /____/_____ Age: _____ *Your Social Security Number: _____

Marital Status: (circle one) M S W D Spouse's Name: _____

In an emergency, Notify: _____ At Telephone Number: _____

Whom may we thank for referring you to our office? _____

Insured Person's Information:

Insured's Name: _____

Insured's Employer: _____

*Insured's S.S. Number: _____ Insured's Date Of Birth: ____ /____/_____

Relationship to patient: _____ Name of Insurance Carrier: _____

Health Information:

Have you had previous chiropractic care? Y / N Where? _____ When? _____

Major Complaint (Why are you here today?) _____

_____

_____

How long have you had this condition? _____ Have you had this problem in the past? Y / N

Other Health Complaints: _____

_____

What activities are you not able to do now, that you were able to do prior to this injury/condition? _____

_____

_____

Check all items this condition is interfering with:

WORK _____ SLEEP _____ DAILY ROUTINE _____ OTHER _____EXPLAIN:_____

_____

How long since you've felt really good? _____

Primary Care Physician (PCP): _____

Surgical Operations and years: _____

_____

Medications you now take: _____

_____

_____

Vitamins/Herbs that you take? _____

_____

Is your condition due to an Auto Accident? _____ Yes _____ No

If yes, Date of Accident _____/_____/_____

If yes, please describe the Auto Accident: _____

_____

_____

_____

Is your condition due to a Job Related Injury? _____ Yes _____ No

If yes, Date of Accident _____/_____/_____

If yes, please describe the Job Related Injury:_____

_____

_____

_____

Have you ever been in any automobile accidents? _____Yes _____ No

If yes, Date of Accident _____/_____/_____As close as you can be.

If yes, please describe the Auto Accident: _____

_____

_____

Have you ever had any other Personal Injury Accidents? _____Yes _____ No

If yes, please describe the Personal Injury Accidents: _____

_____

_____

Date of your last physical exam _____/_____/_____

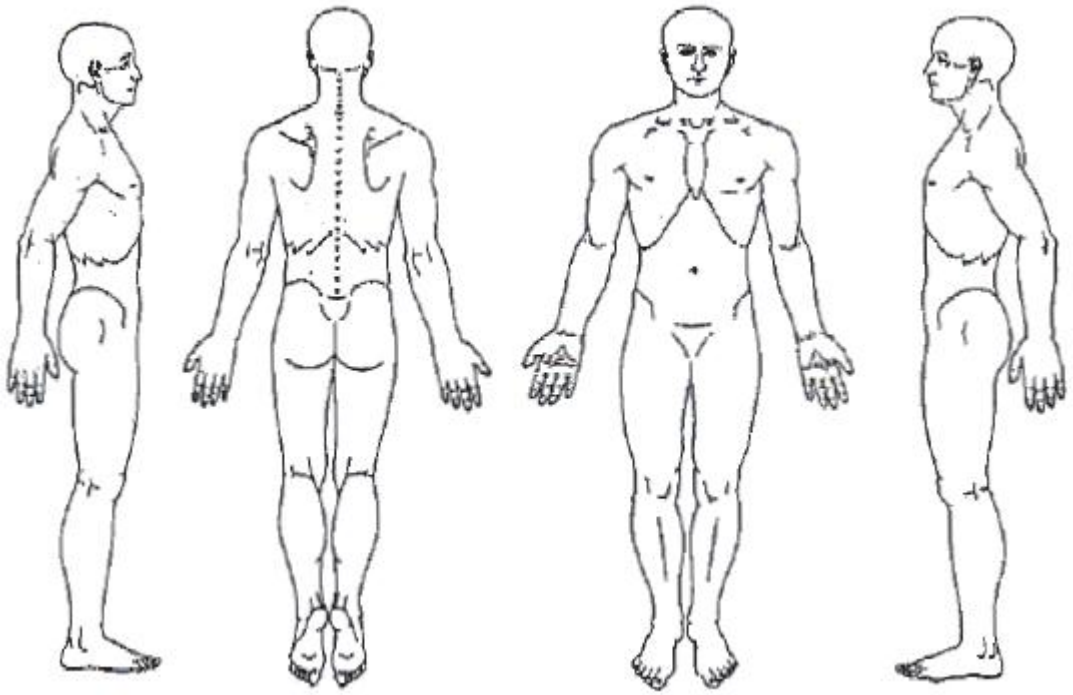
Females: Is there any chances that you may be pregnant? _____Yes _____ No

List any person(s) we may share your information with:_____

_____

What is your pain level? 1 2 3 4 5 6 7 8 9 10

Please circle ALL areas that are affected.



If you do not agree, please cross out the paragraph in question and do not initial it.

_____The above information is current and accurate, including my name, address, phone number, and insurance information.

_____I certify that a copy of the "Notice of Privacy Practices" of Kozik Chiropractic was available to me (Note that this is also prominently displayed in the office).

_____ I authorize payment of insurance benefits directly to Dr. John J. Kozik or the Chiropractic Office for service(s) rendered.

I also understand that Dr. John J. Kozik is associated with Corry Memorial Hospital and Millcreek Community Hospital and that my pertinent information may be shared with those hospitals if necessary.

AUTHORIZATION AND RELEASE: 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. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. 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 that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Relationship to Patient:_____

* For billing purposes only. If you wish not to provide us with this information you may be responsible for all payments.