

What activities are you not able to do, that you were able to do, prior to this incident? _____

How long since you've felt really good? _____

Primary Care Physician (PCP): _____

Surgical Operations and Dates: _____

Date of your last Physical Exam ____/____/____

Females: Is there any chance you may be pregnant? Yes No

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

Medications you now take: _____

Vitamins/Herbs that you take? _____

Is your condition due to an Auto Accident? Yes No. If yes, Date of Accident ____/____/____

Have you ever been in any Automobile Accidents? Yes No. Date of Accident ____/____/____

Please describe any Auto Accidents: _____

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 had any other Personal Injury Accidents? Yes No. When? ____/____/____

If yes, please describe the Personal Injury Accidents: _____

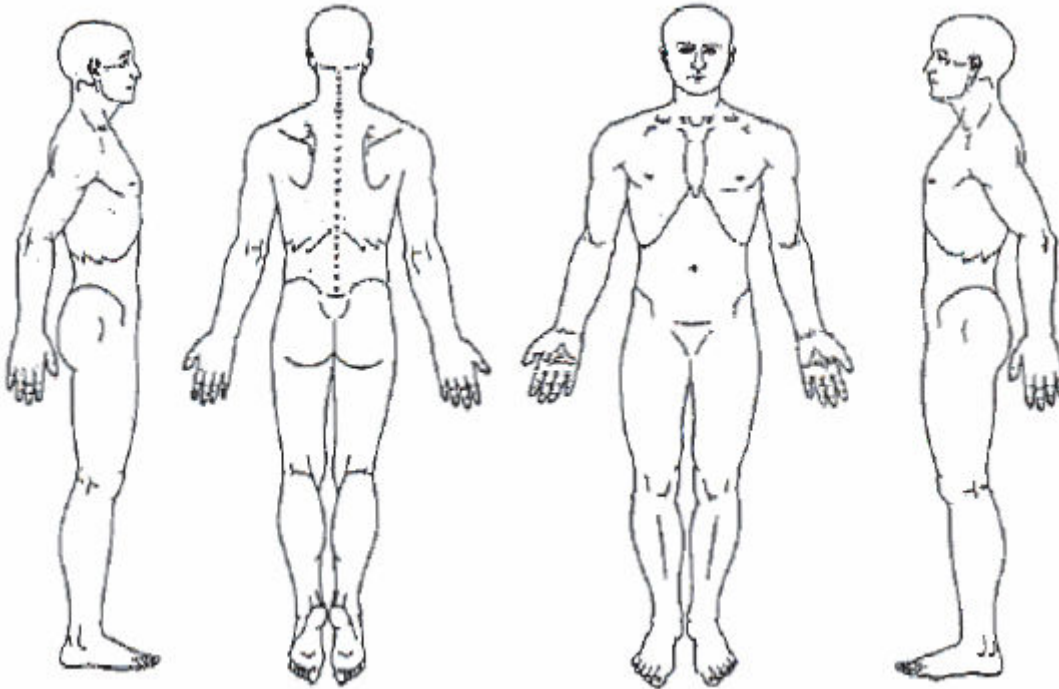
Are any Insurance Claims Open on the above Incidents? Yes No. Claim # _____

Insurance Provider _____

Provider's Address _____

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

Please place an X at 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 payments.