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**FIRST VISIT REGISTRATION**

**Thank you – wellbodyKC looks forward to getting you well soon!**

email: [support@wellbodykc.com](mailto:support@wellbodykc.com) [www.wellbodykc.com](http://www.wellbodykc.com) 2111 East KC Road,

Olathe, Ks 66061

phone: 913-430-8905 fax: 913-222-1907

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Description automatically generated**DOUBLE CLICK ABOVE TO ENTER NAME AND BIRTHDAY**

**ONCE COMPLETED DOUBLE CLICK BELOW TO CONTINUE**

**Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level: \_\_\_\_\_\_\_\_\_\_\_**

**Team/ Club: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice schedule Hours per week:** **\_\_\_\_\_**

**Competition Season:** (Place an “X” after the correct time when you are “in season”)

Year Round  Winter  Summer  Spring  Fall  I don’t compete

**Next scheduled event:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **I plan to compete/perform at this event:** YES NO

1. **Past Medical History:** (include fractures, dislocations, asthma, diabetes, hospitalizations, etc.)

1. **Past Surgical History:** (include ear tubes, tonsillectomy, appendectomy, orthopedic procedures)  
   Procedure Date

1. **Medicines I take every day:** (include prescription, over the counter, supplements, vitamins, alternative)

Medicine Dosage (if you know it)

1. **Medicines I take every once in a while:** (include Tylenol, ibuprofen, creams, alternative)

Medicine Frequency (daily, weekly, monthly, rarely)

1. **Allergies** to medicines/ foods/ environmental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_None
2. I received **immunizations** and am up to date: Yes No

I received a COVID immunization Yes  Never had

I last had COVID on this date: Never had Randy

1. **During every week I eat something in this food group:** (Place “X” after each of what you eat/drink)

Meat/Fish  Fruits Vegetables  Grains  Water  Desserts  Soda/Pop

1. **I have had this many stress fractures diagnosed:** (extremity/back): Never had
2. **I have had this many concussions:** Number: Never had
3. **School:** “X” after correct response: Public/Private  Home College  I don’t go to school

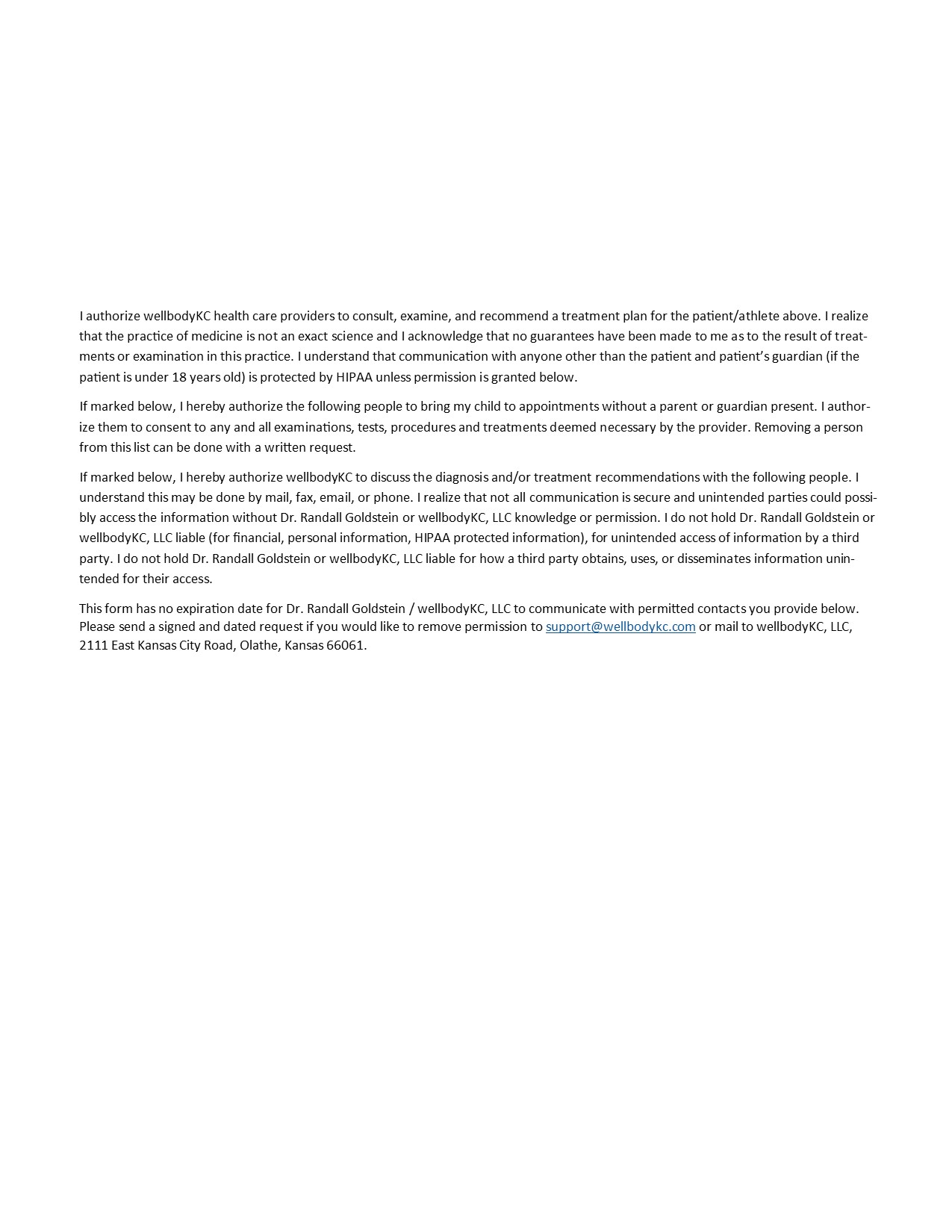
1. **I get this kind of treatment at least once a month:** (Place an “X” after all that apply)

Massage  PT Chiropractor Dry needling Cryotherapy Other: **\_\_\_\_\_\_\_\_\_**

1. **Today’s appointment**: My question / my problem / my concern/ my goals for today:

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Description automatically generated **CONSENT FOR EXAMINATION, MEDICAL TREATMENT**

****

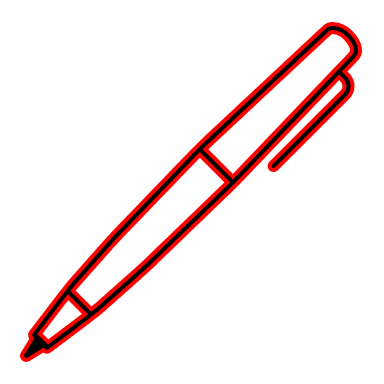
Bring to Communicate **Full Name Relationship to Patient Phone # or email**

clinic HIPAA release

inform my coach  **Coach Contact:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email or Phone:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

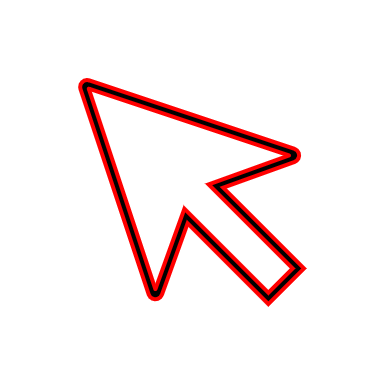
inform my doctor  **Primary Care Provider:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Email or Phone:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I have read and consent to the above information. I was offered access to the wellbodyKC HIPAA information handout**

**Signature of Parent/Guardian:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date:**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(or Patient/athlete if over 18 years ) **Go to menu at top of page and hit “Draw”, select a pen and sign.**



** When completed go to top of page menu and hit the cursor icon to continue typing.**

**Printed name of Parent/Guardian:**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip:**  **\_\_\_\_\_\_\_\_\_\_**

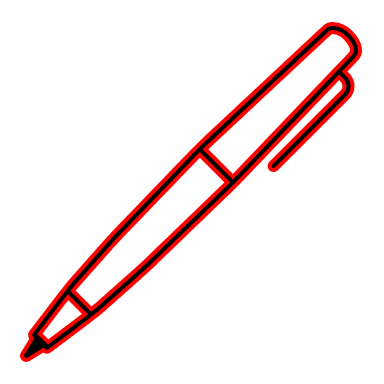
**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[** \_\_\_\_\_\_\_\_ **] Initial here to permit NON encrypted communication**

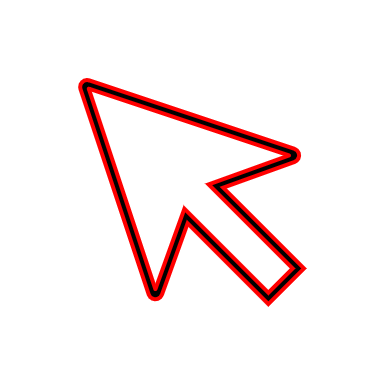
**to the contacts listed for the above patient**

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Description automatically generated** wellbodyKC Financial Policy- All Members** 3/2023

**Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(or patient if over 18 years old and Guarantor) **Go to menu at top of page and hit “Draw”, select a pen and sign.**

**When completed go to top of page menu and hit the cursor icon to continue typing.**

Logo

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**IN NETWORK COMMERCIAL INSURANCE PLANS**

**(BCBS, Anthem, UHC, UMR, Aetna, Cigna), not in network with Medicaid products within these plans**

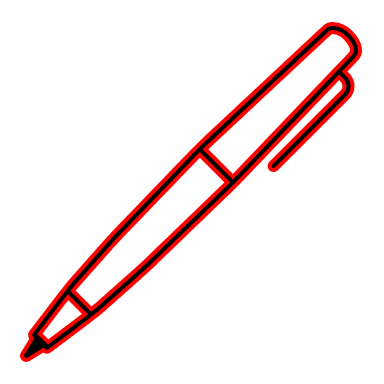
**not in network with Exchange Benefit or Marketplace plans**

**The Guarantor for the Insurance Policy is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**  **Usually the mother or father**

**Name of Guarantor Date of Birth if CIGNA insurance**

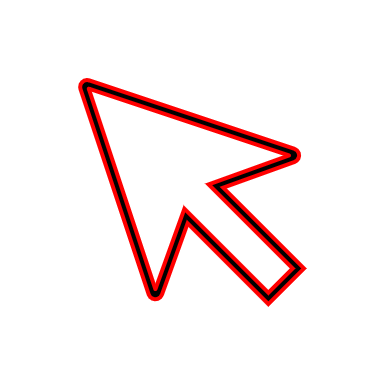
Text, letter

Description automatically generated

**Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(or Patient/athlete if over 18 years old and Guarantor)

**Go to menu at top of page and hit “Draw”, select a pen and sign.**

**When completed go to top of page menu and hit the cursor icon to continue typing.**

**Save and email to** [**support@wellbodykc.com**](mailto:support@wellbodykc.com) **or fax to 913-222-1907 or bring to visit.**

**Thank you!**