KOALA Health & Wellness Centers Inc.

PATIENT INFORMATION RECORD

General Information

Patient Name _____ DOB _____ Social Security _____

Address _____ City _____ State _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Your Employer _____ Occupation _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Children: ☐ Yes ☐ No Ages: _____

Primary Language Spoken _____ E-Mail Address: _____

Emergency Contact _____ Relationship _____ Contact # _____

How did you hear about us? _____

If you are under 18 years of age:

Parent /Guardian Name _____ Contact Ph # _____

Student at _____ Grade Level _____

Sports Played / Other Activities _____

Authorization to Treat:

This is to certify that Koala Health & Wellness Centers, Inc. & all its subsidiaries have been authorized to render treatment and testing to

_____.

Parent / Guardian Signature: _____ **Date:** _____

Billing Information: Do you have Health Insurance? ☐Yes ☐No Any Secondary Insurance? ☐ Yes ☐ No

Plan Name _____ Ph # _____ ID # _____

Group # _____ Insured's Name _____ Insured's DOB_____

Insured's Employer _____ Relationship to Insured _____

PLEASE PROVIDE ALL INSURANCE CARD (S) TO FRONT DESK FOR COPYING & VERFICATION OF YOUR BENEFITS

Verification of Non-Pregnancy (Women Only):

This is to certify that, to the best of my knowledge, I am not pregnant and you have my permission to perform diagnostic X-Ray examination. I have been advised that X-Rays can be hazardous to an unborn child. Date of last menstrual period: _____.

Signature: _____ **Date:** _____ **Parent / Guardian Initials:** _____

I understand and agree that health policies are an arrangement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from an insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment. I authorize this office to release any medical information relating to my treatment to any insurance companies, which may be responsible for paying benefits for treatment rendered to me. I also agree and assign benefits payable to Koala Health & Wellness Centers for all services rendered to me.

Signature: _____ **Date:** _____ **Parent / Guardian Initials:** _____

(turn over)

Medical History & Information

What is the problem that brings you to see us? _____

How did it happen? _____

How long has it been going on? _____ Have you had the same or similar problem before? ☐ Yes ☐ No

What aggravates the condition? _____

What makes it feel better? _____

Is the condition getting worse? ☐ Yes ☐ No Are the symptoms you are experiencing ☐ Constant? ☐ Come & Go? ☐ Interfering w/ work?

☐ Interfering w/ sleep? ☐ Interfering w/ daily routine? ☐ Training? ☐ Other? _____

Are there any other healthcare providers that have seen you for this condition? ☐ Yes ☐ No If yes, please list below.

Provider Name	Type of Provider	Last Visit Date

Are you currently taking any medications and/or pain medications? ☐ Yes ☐ No (please list them to include the dosage and frequency)

_____ _____

_____ _____

Known Allergies:	**Adverse Reactions to Medications:**

Have you had any major surgical procedures within the last 60 days? ☐ Yes ☐ No Please List _____

_____

List prior surgeries / Hospitalizations and dates: _____

_____

Family History **Personal Medical History**

Condition	Yes	Comments / Who?	Condition	Yes	Comments
Heart Trouble			Digestive Disorders		
Stroke			Sinus Troubles		
Cancer			Asthma/ Respiratory		
Diabetes			Dizziness		
Arthritis / Joint			Nervousness		
Hypertension			Numbness/Tingling		
			Pregnancy		
			Backaches/ Back Pain		
			Headaches		
			Hernia		
			Nausea/vomiting		

Please list any other conditions which are not listed: _____

Informed Consent

In consideration of accepting evaluation and treatment I _____, give the doctor permission to care and treat my condition through assessment, testing, diagnostic, impressions, therapeutic modalities, spinal manipulations, and conclusions based on the findings. I understand that it is my responsibility to make known any and all information about myself not excluding symptoms, injury mechanism, history, pathological defects, illnesses, or deformities that would not come to the attention of the doctor. I understand that all conditions respond differently to treatment and that occasionally, results are less than expected. I do understand that in the event my condition is not responsive that I may be referred to another health care specialist that works with our doctors to evaluate my health care regimen. Furthermore, I grant permission to use my records, photographs, and/or videotapes for any legitimate research purposes.

Signature: _____ **Date:** _____ **Parent / Guardian Initials** _____