Family Care Chiropractic

Jaime Gonzalez, D.C.
10110 Dixie Highway, Louisville, KY 40272

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Name _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Cell Phone Number _____

Email _____

By providing my mobile number / email address, I authorize my doctor to contact me via text or email address.

Date of Birth: _____ Age _____ Gender *(check one)* ❑ Male ❑ Female

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other Social Security Number: _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Please list your current medications if any:

Please list your current medications, including frequency and dosage if known and when you starting taking them.
If there are no current medications, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Briefly list your main health problems or areas of pain and rate each from 0 to 10: _____

_____

_____

☺ ☹

0 1 2 3 4 5 6 7 8 9 10

No Pain Some Pain Lots of Pain Extreme Pain

Have you had an X-ray or CT scan or MRI of your neck, mid back or low back in the past 30 days? ❑ Yes ❑ No

If so, where? _____ What was the diagnosis? _____

_____
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Health History:

What treatment have you already received for this condition:

Chiropractic Care Medication Surgery Physical Therapy Other: _____

Please mark YES or NO if you have or have had any of the following:

AIDS / HIV	O Yes	O No	Diabetes	O Yes	O No	Liver Disease	O Yes	O No	Rheumatic Fever	O Yes	O No
Alcoholism	O Yes	O No	Emphysema	O Yes	O No	Measles	O Yes	O No	Scarlet Fever	O Yes	O No
Allergy Shots	O Yes	O No	Epilepsy	O Yes	O No	Migraine Headache	O Yes	O No	Stroke	O Yes	O No
Anemia	O Yes	O No	Fractures	O Yes	O No	Mononucleosis	O Yes	O No	Thyroid Problems	O Yes	O No
Appendicitis	O Yes	O No	Glaucoma	O Yes	O No	Multiple Sclerosis	O Yes	O No	Tuberculosis	O Yes	O No
Arthritis	O Yes	O No	Gout	O Yes	O No	Mumps	O Yes	O No	Tumors / Growths	O Yes	O No
Asthma	O Yes	O No	Heart Disease	O Yes	O No	Osteoporosis	O Yes	O No	Ulcers	O Yes	O No
Bronchitis	O Yes	O No	Hepatitis	O Yes	O No	Pacemaker	O Yes	O No	Whooping Cough	O Yes	O No
Cancer	O Yes	O No	Herniated Disc	O Yes	O No	Parkinson's	O Yes	O No	Other: _____		
Cataracts	O Yes	O No	High Blood Pressure	O Yes	O No	Prosthesis	O Yes	O No	_____		
Chicken Pox	O Yes	O No	High Cholesterol	O Yes	O No	Psychiatric Care	O Yes	O No	_____		

For any YES marked above, please explain: _____

_____

Please describe any other pertinent information: _____

_____

Family History:

Do any of your parents or their parents have or had stoke, high blood pressure, high cholesterol, diabetes heart attack or cancer?

Mother: Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Father: Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Mother's mother:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Father's mother:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Mother's father:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Father's father:
Stroke, ↑ Blood Pressure, ↑Cholesterol, Diabetes, Heart Attack
Cancer: _____ Other: _____
No known adverse history

Please Print Patient Name Patient or Guardian Signature Date:

_____ _____ _____

_____
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Family Care Chiropractic

10110 Dixie Highway ● Louisville, Kentucky 40272 ● (502) 937-7995 ● Fax: (502) 937-5560
louisvilledc@hotmail.com www.jgonzalezdc.com

IRREVOCABLE ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay my Healthcare Provider (Jaime Gonzalez, DC / Family Care Chiropractic – Valley Station, 10110 Dixie Hwy Dixie Highway, Louisville, KY 40272), as well as all employees, employers, contractors, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any chiropractic services rendered and for any supplies, x-rays, tests, therapeutic modalities provided.

I hereby authorize payment of, and assign my rights to, any health insurance, auto insurance, or medical plan benefits directly to Healthcare Provider (Jaime Gonzalez, DC / Family Care Chiropractic) for any and all medical/healthcare services, chiropractic services, supplies, tests, therapeutic modalities that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance, auto insurance or medical plans which I may have benefits under.

I hereby authorize the release of my health status, conditions, symptoms or treatment information and the release of my records to my insurance company and attorney that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider (Family Care Chiropractic – Valley Station) all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, auto insurance or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Please Print Patient Name _____ Patient or Guardian Signature _____ Date: _____

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Dr. Intials