

40 South Street
Eatontown, NJ. 07724

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732-389-2800

CASE HISTORY UPDATE

PERSONAL INFORMATION

Name _____ Date: ___/___/___

If your contact information has not changed, skip to next section

Address _____ City _____ State _____ Zip _____

Home Tel.# (____) _____ Work Tel. #(____) _____ Cell Phone # (____) _____

Email: _____

YOUR HEALTH CONDITION

Reason for Visit: Routine Check-up Re-Aggravation of Old Injury New Injury (Please Describe Below)

What is your major complaint? _____

When & how did it occur? _____

Other doctors seen for this condition: _____

Rate pain on a scale from 1-10 (Circle One, 10=Most Painful) 1 2 3 4 5 6 7 8 9 10

Since your last appointment, have you had any surgical procedures, fractures, or any traumatic injuries? **Y or N**

FEMALE PATIENTS ONLY

Are you currently or do you have any reason to believe you are pregnant? **Y N.**

HEALTH INSURANCE INFORMATION

If insurance information has not changed, skip this section

Insurance Name & Address: _____

Policy #: _____ . Are you covered by Medicare? **Y N.**

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by Dr. Kovacs at the Eatontown Elite Care Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature: _____ Date: _____

OFFICE POLICIES

While we will assist in the insurance verification process, You the patient are ultimately responsible to check with your insurance company to verify Chiropractic coverage before treatment begins, i.e., if a referral is needed. Patients are responsible to obtain all referrals (if needed). If your policy requires a referral, you must present referral to front desk, before you are seen by the doctor. If treatment is rendered and referral was not obtained/presented, you the patient will be responsible for payment.

Co-Payments are due at the time chiropractic services are rendered. Insurance companies forbid the waiving of deductibles or co-payments by healthcare providers. Co-Insurance must be paid in full.

ALL appointment cancellations must be confirmed within 24 hours of your scheduled time. Office charges for time reserved will apply for ANY appointments cancelled without proper notice.

I understand that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me and/or my attorney (if applicable, charges may apply) in making collection or settlement from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I irrevocably authorize, direct and instruct my attorney (if applicable) to make payment to Dr. Kovacs from my settlement, fees due, to his office as mandated within the PIP fee schedule. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

I hereby attest all information given above is true to the best of my knowledge.

Patient Signature: _____ Date: _____