Jex Chiropractic Health Center. 533 S. 336th St. Suite A. Federal Way, WA 98001.
PHONE: (253) 838-1080 FAX: (253) 838-2551)

Patient Information

Name:_____ Date: _____
Cell Phone: _____ Home Phone: _____
Date of Birth: _____ / _____ / _____ Sex: Male Female Other
Street Address: _____
City: _____ State: _____ Zip: _____
Marital Status: Married _____ Single _____ Divorced _____ Minor _____
How did you hear about us? _____

I would like to receive text message/email appointment reminders: YES NO
If Yes for TEXT message reminders, who is your cell phone carrier: (Please circle one)

TMOBILE, VERIZON, SPRINT, METRO, AT&T, CINGULAR, US CELL, VIRGIN, BOOST,
OTHER:_____
Email: _____

Employer

Company Name: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ FAX: _____

Spouse/Partner

Name: _____ Date of Birth: ____ / ____ / _____
Phone Number for Emergency Purposes: _____

Primary Patient Insurance Information

*Please provide a copy of insurance card **OR** fill out the following information.*

Insurance Name: _____ Insurance Phone: _____
Insurance ID#: _____ Group#: _____
Relationship to Insured: SELF SPOUSE CHILD

Secondary insurance information

Insurance Name: _____ Insurance Phone: _____
Insurance ID#: _____ Group#: _____
Relationship to Insured: SELF SPOUSE CHILD

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Brief Medical History

If pain brought you in today, are you aware what caused it? YES NO
If yes, explain: _____

Cause of Injury if applicable: AUTO ACCIDENT WORK INJURY HOME INJURY
OTHER: _____ Date of Injury: _____
(Additional Paperwork and information will be necessary for Auto and work injuries.)

What is your level of discomfort: MILD MODERATE SEVERE VERY SEVERE

How long has this problem persisted? _____
What activities aggravate your condition? _____

Please list all medications (over the counter included) or proved a printed copy:

_____

_____

Do you take aspirin or blood thinners? YES NO

Are you Pregnant: YES NO *If **YES**, when is your due date?:* _____/_____/_____

Please circle any of the following symptoms and/or conditions you may have:

AIDS/HIV	DIZZINESS	INSOMNIA	PINCHED NERVES
ALLERGIES	EAR BUZZING/RINGING	IRRITAL BOWL	PINS & NEEDLES
ANEMIA	FAINTING	IRRIABILITY	RINGING IN EARS
ANXIETY/NERVOUSNESS	FATIGUE	LIGHT SENSITIVITY	SINUS TROUBLE
ARTHRITIS	FEVER	LOW BACK PAIN	SWOLLEN ANKLES
ASTHMA	FOOD ALLERGY	LOW BLOOD PRESSURE	SWOLLEN JOINTS
BLEEDING DISORDER	GALL BLADDER DISEASE	LOSS OF MEMORY	SHORTNESS OF BREATH
BLURRED VISION	GRADING IN NECK	LOSS OF BALANCE	ARM/SHOULDER PAIN
CANCER	GOUT	LOSS OF SMELL	STOMACH PAIN
COLD HANDS	HEART DISEASE	MENSTRAUL PROBLEMS	STRESS
COLD FEET	HIGH BLOOD PRESSURE	MID BACK PAIN	STROKE
COLD SWEATS	HEADACHES	MIGRAINES	SLEEPING ISSUES
CHEST PAIN	HEAVY HEADEDNESS	MUSCLE SPASMS	TENSION
CONSTIPATION	HERNIATED DISC	NAUSEA	THYROID DISEASE
DIARRHEA	HYPERTENSION	NECK PAIN	TIGHTNESS
DIABETES	INDIGESTION	NUMBNESS	TWITCHING OF FACE
DEPRESSION	INTESTINAL GAS	PAIN IN JOINTS	ULCERS

Other Symptoms/Conditions not listed: _____

Do you sleep on your: BACK SIDE STOMACH OTHER: _____

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Previous Treatment:

Have you had Chiropractic before? YES NO
IF YES, Who did you see? _____
Date of last visit? _____ Did they take x-rays? YES NO
If YES, When were they last taken? _____

Health and Medical Information Release Form

I, _____, give my permission to Dr. Kevin S. Jex, his staff, associates, and employees of Jex Chiropractic Health Center to share private and medical information with my medical doctor, _____, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Kevin S. Jex and his staff.

Medical Doctor Information

Name of Primary Care Doctor: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Have you treated with them for this condition? YES NO
Do you have a follow-up appointment scheduled with them? YES NO

Billing and Authorization

By signing this page, I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits to either myself or to the party who accepts assignments. This is a permanent authorization that I may revoke at any time by written notice.

Financial Responsibility

Also, by signing this page, I understand I am personally financially responsible for all services not paid by my insurance, work injury, or auto accident. I am also responsible for any annual deductibles applicable, copayments, co-insurances, or any and all non-covered services as may be required by my insurance.

Cancelation Notice

I understand I must give 48 hours' notice to change or cancel an appointment.

Please sign below to signify all information you provided is true and accurate, and you understand and approve all responsibilities and authorizations listed above:

_____ _____
Signature of patient Date

_____ _____
Name Printed Relationship to patient (IF not patient)

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Notice of Privacy Practices Acknowledgment (HIPPA)

I understand that under the **Health Insurance Portability and Accountability Act** of 1996 (or HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and or indirectly.
2. Obtain payment from insurance companies and third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of privacy practices*.

I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. In addition, I understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____

Patient Name (Printed) : _____ Date: _____

Relationship to Patient (IF not patient): _____

I do **NOT** agree to this consent and do not wish to sign: _____ Initial: _____

Please provide a reason for refusal of HIPPA Compliant Signature Above: _____
_____
_____

Office Staff Only:

I attempted to obtain the patient's signature in acknowledgment of this *Notice of privacy practices*, but I was unable to do so as documented below:

Reason: _____

Date: _____ Initials of Staff: _____