Joly Chiropractic
Dr. Joseph J. Joly
3909 Stevenson Blvd. Ste. D
Fremont, CA 94538
Text or Call (510) 249.9037
JJGotYourBack247.com

Patient Information

Last Name_____ First Name_____ MI_____

Address _____ City_____ State/Zip_____

Home Phone (_____) _____-_____ Alternate Phone (_____) _____-_____

Email Address _____@_____

Would You Like Text Message Reminders of Your Appointment? **Yes** **No**

Age _____ Birthdate ____/____/____ Marital Status **M** **S** **W** **D** # of Children _____

Occupation_____ Employer_____

Work Phone (_____) _____-_____ City/State/Zip_____

Referred By

Name_____ Relationship_____

Emergency Contact

Contact Name_____ Relationship_____

Address _____ City_____ State/Zip_____

Home Phone (_____) _____-_____ Alternate Phone (_____) _____-_____

History

Date of Last Physical Exam_____ Primary Care Physician_____

What operations have you had? When? _____

Serious Illnesses?_____

_____

Fractured Bones? _____

Medications: Please list all prescriptions/non-prescriptions medication you are taking on a regular and/or occasional basis _____

_____

Have You Ever Had Chiropractic Care? **Yes** **No** Doctor's Name_____

Primary Purpose of This Appointment (Major Complaint) _____

_____

Is this Condition Due to an Injury or Sickness From Employment? **Yes** **No** Auto Accident? **Yes** **No**

Date Symptoms appeared/Date of Accident ____/____/____ Lost Days From Work? _____

Have You Ever Had Similar Conditions? **Yes** **No** If Yes, When? Please Describe _____

_____

Activities That Aggravate Your Condition _____

Is Your Condition Getting Progressively Worse? **Yes** **No**

Is Your Condition Interfering with Your: ____Work ____Sleep ____Daily Routine ____Other

How Long Has it Been Since You Felt Good? _____

Other Doctors Seen For This Condition? When? _____

Females Only

Are You or Could You be Pregnant? **Yes** **No**

Do You Have Any Breast Problems? **Yes** **No**

Do You Have Menstrual Problems? **Yes** **No**

Do You Take Birth Control? **Yes** **No**

Review of Systems

Do you have skin, hair, or nail problems?_____**Yes** **No**

Do you have mouth and/or throat problems?_____**Yes** **No**

Do you have nose and/or sinus problems?_____**Yes** **No**

Do you have ear problems?_____**Yes** **No**

Do you have eye problems?_____**Yes** **No**

Do you have chest or lung (breathing) problems?_____**Yes** **No**

Do you Smoke?_____ Cigarettes per day?_____ How long have you smoked?_____

Do you have heart and/or blood vessel problems?_____**Yes** **No**

Do you have blood or lymph node problems?_____**Yes** **No**

Do you have digestive problems?_____**Yes** **No**

Do you have genital problems? (Ex. Prostate, testicular, vaginal)?_____**Yes** **No**

Do you have urinary (including kidney or bladder) problems?_____**Yes** **No**

Do you have any gland and/or hormone problems?_____**Yes** **No**

Do you have allergy or immunity problems?_?_____**Yes** **No**

Do you have any muscle, tendon, or ligament problems?_____**Yes** **No**

Do you have any bone or joint diseases (Ex. osteoporosis, arthritis)?_____**Yes** **No**

Do you have any nervous system, disease and/or mental health problems?_____**Yes** **No**

Any Additional Information _____

_____

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform the office.

Patient's Signature_____ Date_____/_____/_____

Parent/Guardian Signature_____ Date_____/_____/_____

Insurance Information

Are You Insured? **Yes** **No**

Name of Person Responsible for Payment_____ SSN____-____-____

Relationship to Patient_____ Insured's Date of Birth____/____/____

Insurance Company_____ Policy/Member #_____

Claims Address_____ City_____ State/Zip_____

Credit Guarantee Insurance Assignment & Personal Balance

Insurance Assignment: Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

Filing Procedure: Claims for initial services are submitted within 48 hours after your visit. On day 90, if your insurance company had not paid the bill, we will change your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you. Please keep in mind this office will not bill your card without first trying to contact you.

Personal Balance: Estimated personal portions are paid at the time of service.

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Print Patient's Name_____

Patient's Signature_____ **Date**____/____/____

Parent/Guardian Signature_____ **Date**____/____/____