Joly Chiropractic
Dr. Joseph J. Joly
1860 Mowry Ave, Suite 103
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 ___ / ___ / ____