KENT SPORT & SPINE

CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Preferred Name:_____

Address: _____City:_____State:_____Zip:_____

Patient's Gender: ☐ Male ☐ Female ☐ X Age: _____ Date of Birth:_____

Email Address: _____ (For billing purposes)

Best phone number to contact you: _____ ☐ Home ☐ Mobile ☐ Work

Authorization to end Text Reminders via Google voice (Circle One) YES / NO Initials_____

Patient's Employer: _____ Patient's Occupation:_____

☐ Married ☐ Single ☐ Divorced ☐ Other Children **YES/NO** How many? _____

Spouse's Name: _____ Spouse Phone #: _____

Emergency Contact Name: _____ Relation to You: _____

Have you had previous chiropractic care? (Circle One) YES / NO If so, When? _____

Primary Care Physician (PCP): _____

Phone number: _____

Who may we thank for referring you? _____

REQUIRED FOR ALL PATIENT FOR COMPLIANCE BY THE CENTER FOR MEDICARE/MEDICAID SERVICES:

Race/Ethnicity (check) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African America

☐ Native Hawaiian or Pacific Islander ☐ White ☐ Hispanic or Latino ☐ Other ☐ Prefer not to say

PATIENT AGREEMENT (PLEASE READ CAREFULLY) I authorize treatment of the patient named above and agree to pay all charges for such treatment that may or may not be covered by my insurance. I also authorize the provider to release any information to referring/consulting physicians or other health care providers that may be necessary to facilitate care. I certify that a copy of this agreement shall be valid as the original.

_____ _____

Patient or Legal Guardian Signature Date

Patient Name: _____ Doctor's Initials: _____

1. When did your symptoms first begin (give date if possible)? _____

2. Is your condition caused by a specific accident/injury? ☐ **Yes** ☐ **No** ☐ **Auto** ☐ **Work**

If yes, please explain:

3. Draw the area of your symptoms using these symbols:

■ = Severe Pain

☆ = Moderate pain

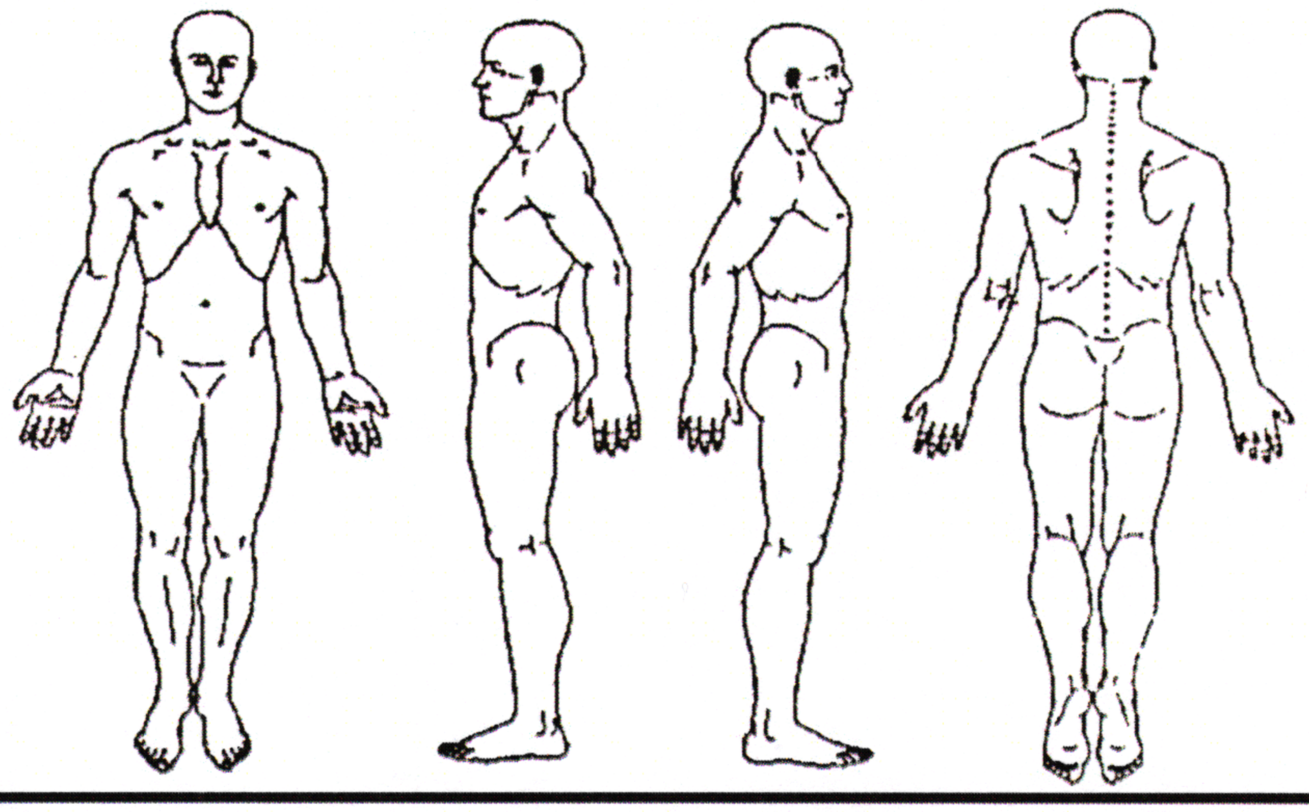
XXX = Ache/tight

\\\\ = Numbness

↓ ↓ = Shooting pain

***** = Tingling**

Pain Diagram



Circle your primary concern, the intensity, and frequency experienced over the past 2 weeks. If applicable, complete the same for your second complaint.

PRIMARY CONCERN

Head | Neck | Mid Back | Low Back

Extremity _____

Pain Intensity

0 1 2 3 4 5 6 7 8 9 10

No pain Mild Moderate Severe Worst imagineable

SECONDARY CONCERN

Head | Neck | Mid Back | Low Back

Extremity _____

Pain Intensity

0 1 2 3 4 5 6 7 8 9 10

No pain Mild Moderate Severe Worst imagineable

What else should Dr. Zografos know about your current condition? _____

_____

Medications: _____

_____

NOTICE TO NEW PATIENTS: **Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Doctor to use the information in my medical record to assist in the clinical improvement process.**

Patient Signature: _____ **Date:** _____

Patient name: _____ Date: _____ Doctor's Initials: _____

1. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck Pain	○	○	Back Problems	○	○	Hip Disorders	○
○	○	Knee Injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ Issues	○	○	Poor Posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and Needles	○	○	Numbness	○
																		Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	High Blood pressure	○	○	Low Blood pressure	○	○	High Cholesterol	○	○	Poor Circulation	○	○	Angina	○	○	Excessive bruising	○
																		Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay Fever	○	○	Shortness of breath	○	○	Pneumonia	○
																		Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	○
																		Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	○
																		Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	○
																		Initials ____

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Thyroid issues	○	○	Immune	○	○	Hypoglycemia	○	○	Frequent	○	○	Swollen glands	○	○	Low energy	○
																		Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptom	○
																		Initials ____

j . Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Have	Had		None
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	○
																		Initials ____

2. Family History Some health issues are hereditary. Tell Dr. Zografos about the health of your immediate family members

Family	Age (if living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sisters	_____	○	○	_____	_____	○	○
Brothers	_____	○	○	_____	_____	○	○

Patient name: _____ Date: _____ Doctor's Initials: _____

3. Are there any other hereditary health issues that you know about?_____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, and treatments. Please complete each section fully.

4. Illnesses

Check the illness you have **Had** in the past or **Have** now

Had	Have	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	HIV Positive
○	○	Sexually transmitted disease
○	○	Measles
○	○	Malaria
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic Fever
○	○	Scarlet Fever
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other

_____

_____

5. Operations

Surgical interventions, which may or may not have included hospitalization

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery _____

_____

- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____

_____

_____

- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

_____

6. Treatments

Check the ones you've received

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy

7. ALLERGIES

Are you allergic to any medications?

○ yes ○ No

if yes please list:

_____

_____

_____

8. INJURIES Have you ever...

- ○ Had a fractured or broken
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch
- ○ Used neck or back bracing
- ○ Had a body piercing
- ○ Received a tattoo

9. Social History Tell Dr. Zografos about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much?	_____
Coffee/Caffeine use	○ Daily	○ Weekly	How much?	_____
Tobacco use	○ Daily	○ Weekly	How much?	_____
Exercising	○ Daily	○ Weekly	How much?	_____
Pain relievers	○ Daily	○ Weekly	How much?	_____
Soft drinks	○ Daily	○ Weekly	How much?	_____
Water intake	○ Daily	○ Weekly	How much?	_____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

10. Sleep

How much sleep do you average per night? _____ hours. Do you typically sleep through the night? ○ Yes ○ No

What is the type and approximate age of your mattress and pillow? _____

What is your preferred sleeping position? _____

11. Diet

Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

How often do you eat red meat? ○ Daily ○ Weekly How much? _____

What oil do you primarily cook with? ○ Olive ○ Coconut ○ Corn ○ Canola ○ Other_____

How often do you eat desserts/sweets? ○ Daily ○ Regularly ○ Once in a while ○ Never ○ Other_____

12. What would be the most significant thing that you could do to improve your health?

_____

13. In addition to the main reason for your visit today, what additional health goals do you have?

_____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the results in the shortest amount of time, please read each statement and initial your agreement.

I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials ——

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials ——

I realize that an X-ray examination may be hazardous to an unborn child and certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):

Initials——

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials——

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials——

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented that presence, severity, or cause of my health concern.

Initials——

Patient printed name: _____ **Date:**_____

Patient Signature: _____ Doctor's Initials: _____

KENT SPORT & SPINE

OFFICE FINANCIAL POLICY

Appointments: We realize unexpected situations occur. If your schedule does change and you must cancel or reschedule your appointment, please notify us at least 24 hours prior to your appointment so that we may offer that time to another person. We do charge a $60 fee for massage appointments without 24 hours' cancellation notice. This fee cannot be billed to your insurance company.
INITIALS____

Medicare Patients: Medicare is your primary insurance carrier. We will bill Medicare from our office. Medicare will only pay for services that it determines to be "reasonable and necessary". If Medicare determines that a particular service is not "reasonable and necessary" under Medicare standards, Medicare will deny payment for that service. If Medicare denies any services, your secondary insurance will not cover the service. Current Medicare regulations will not reimburse for the following services: exams, physical therapy, x-rays, supports. Although they will usually pay for treatments, they may not pay for this many treatments overall, or within a certain time period. Non-covered services will be charged directly to you and you will be responsible for payment.
INTIALS____

Auto Accident Patients: If you have PIP or Med-Pay: We will bill your insurance carrier directly. These carriers usually pay 100% of billed charges. If your carrier does not, we will notify you. You will be responsible for unpaid charges. If you do not have PIP coverage, your doctor will discuss options with you. You will be expected to make minimum monthly payments of $100.00 toward your account.
INITIALS____

Workers Compensation Patients: We will bill the workers compensation carrier. In an accepted claim, insurance pays 100% of charges.
INITIALS____

Cash Patients: Payment for services is expected at time of service. We do not bill for services after the fact unless other arrangements have been made. Your doctor will discuss fees with you at the time of service.
INITIALS____

Health Plans: We will bill your insurance carrier for you. If your plan is a managed care plan, and requires a physician referral, we will help you obtain one. However, the responsibility for this referral lies with you. If your plan requires pre-authorization, we will work to obtain this on your behalf. Most health insurance companies require a portion of each visit to be patient responsibility, in the form of a deductible, co-pay and/or co-insurance amount. We will ask for this payment at the time of service.
INITIALS____

Automatic Credit Card Payments: Credit card payments are taken by Square and will be stored on their secure server, off sight from our location. This credit card will be charged ONLY if there is an unpaid balance on your account and ONLY charged when 10 days' notice will be provided to you. This notice will be sent to your email as we will no longer be sending out paper statements. Within that 10-day period, you can call in with another form of payment. Otherwise, your card will be charged. Email Address:_____
INITIALS____

BY SIGNING BELOW YOU HEREBY AUTHORIZE YOUR INSURANCE BENEFITS TO BE PAID DIRECTLY TO KENT SPORT AND SPINE (KSS). YOU AGREE TO NOT WITHHOLD OR DELAY PAYMENT IF YOUR INSURANCE COMPANY DENIES PAYMENT ON ANY OF YOUR CHARGES. IN THE EVENT IT SHOULD BECOME NECESSARY TO FORWARD YOUR UNPAID BALANCE TO A COLLECTION AGENCY, YOU AGREE TO PAY INTEREST AND COLLECTION FEES. IF LEGAL ACTION IS TAKEN AGAINST THIS ACCOUNT, YOU AGREE TO PAY ALL REASONABLE ATTORNY FEES, FILING FEEA AND ANY OTHER COST ASSOCIATED WITH THIS ACTION. CHECKS RETURNED WITHOUT SUFFICIENT FUNDS WILL BE CHARGED A $35.00 FEE. BALANCES UNPAID AFTER 60 DAYS WILL ACCRUE A 1.5% (18% ANNUALLY) FINANCE CHARGE EACH BILLING CYCLE. BALANCES UNPAID AFTER 60 DAYS MUST HAVE PAYMENT ARRANGEMENTS MADE. BALANCES UNPAID AFTER 90 DAYS WILL BE TURNED OVER TO COLLECTIONS.

Patient Printed Name:_____Date:_____

Patient Signature:_____

Personal Responsible for bill (if patient is under 18 years of age) _____

Steve Zografos DC 24909 104th Ave SE Kent, WA 98030 (253) 850.8163

KENT SPORT & SPINE

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's NOTICE OF PRIVACY PRACTICES as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of these rights are available upon request. I understand that this information can and will be used to:

- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations.
- Provide & coordinated treatment along health care providers who may be involved in my care.

Patient Printed Name:_____ Date:_____

Patient or Legal Guardian Signature:_____

Relationship to Patient:_____

(Optional) I authorize the following person(s) to obtain my medical information:

_____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Rights due to the following reason:

- ☐ Communication Barriers
- ☐ Emergency Situation
- ☐ The patient refused to sign
- ☐ Other

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