WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

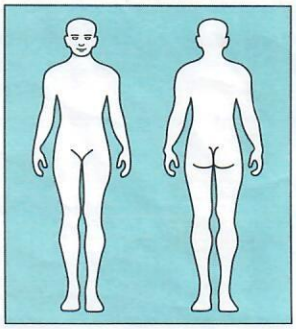
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (____)_____

ALLERGIES

VITAMINS/HERBS/MINERALS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent for Edwin H. Chun, D.C. ("Chun Chiropractic", "this clinic") to use and disclose protected health information (PIH) about me to carry out treatment, payment, and healthcare operations (TPO). (The Notice of Privacy Practices describes such use and disclosures more completely – please request a copy). I have the right to review the Notice of Privacy Practices prior to signing this consent. This clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Chun Chiropractic, 6518 Greenleaf Ave., #25, Whittier, CA 90601. With this consent, this clinic may call my home or other alternative location and leave a message on voicemail or in-person in reference to any items that assist our clinic in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including but not limited to radiology and test results. With this consent, our clinic may mail to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential". I have the right to request any restrictions on how to use or disclose my PHI to carry out TPO. This clinic is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow this clinic to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that this clinic has already made disclosures in reliance upon by prior consent. If I do not sign this consent, or later revoke it, this clinic may decline to provide treatment to me. _____ **(initial)**

CONSENT FOR TREATMENT

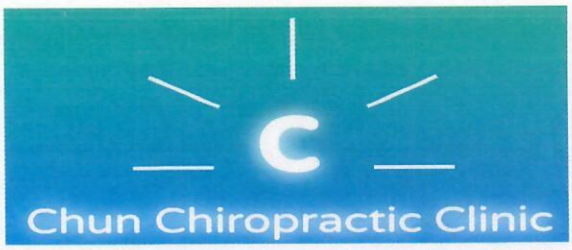
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic modalities and procedures, including but not limited to various modes of physical therapy and diagnostic x-rays on me or the patient named, for whom I am legally responsible for, by Dr. Edwin H. Chun and his staff. I have had an opportunity to discuss with the chiropractor and/or other staff the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that there are some risks to treatment including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the chiropractor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of treatment which the doctor feels at the time, based on the facts then known, is in my best interest. I have read or have had read to me this consent. I have also had the opportunity to ask questions about its content. By signing below, I agree with its content and I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment. _____ **(initial)**

STATEMENT OF FINANCIAL RESPONSIBILITIES/ASSIGNMENT OF BENEFITS

I acknowledge that I am legally responsible for all charges regarding the medical care and treatment provided by representatives of this clinic, Chun Chiropractic under Dr. Edwin H. Chun. I assign and authorize payments to this clinic. I understand my insurance carrier may not approve or reimburse my treatments and services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, medical necessity, or other reasons. I understand I am responsible for fees not paid in full, co-payments and policy deductibles except where my liability is limited by contract or State/Federal law. _____ **(initial)**

Patient or Parent/Guardian Signature **Date**

Printed Patient Name and/or Parent/Guardian Name **Relationship to Patient**



6518 Greenleaf Ave., #25, Whittier, CA 90601 (562) 698-7161

Consent Form

I, _____, hereby grant Edwin H. Chun, D.C. (Whittier, CA), permission to take photographs and/or videos of myself and to publish those photographs for any lawful purpose, including, but not limited to, their website, social media accounts, and promotional materials, either digital or in print, in perpetuity. I also grant permission to use my name.

By signing and dating this document I authorize Edwin H. Chun, D.C. (Whittier, CA), to edit, alter, share, remix, tweak, build upon or in any way alter the photograph(s) and/or videos mentioned above. I also waive any rights of privacy or compensation associated with the use of my or my image(s) and name(s) for the personal or commercial purposes outlined above.

_____ _____

Patient Signature *Date*

_____

Printed Name