Welcome to our office.

Please fill out the following information as completely as possible.

PATIENT INFORMATION

(Please Print Clearly)

Legal First Name: _____ Nickname_____MI:____Last Name: _____

Street Address: _____City: _____State: _____Zip:_____

Home#: _____-_____-_____ Work #: _____-_____-_____ Cell #: _____-_____-_____

E-Mail Address: _____

(We do not share your address with anyone. We use e-mail to send appointment reminders, to notify you of last minute office closures, and other general FHCC information/newsletters.)

Sex: □ M □ F Date of Birth: _____Age: _____ Soc.Sec.#: _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation: _____ Employer Name _____

Spouse's Name: _____ Spouse's Employer: _____

Name and age of children: _____

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? □ No □ Yes (immediately notify front desk) Your Initials:_____

If yes: Date of Accident: _____ Time of Accident _____ Claim #: _____

Pregnant: □Yes □No Pacemaker: □Yes □No Family Physician_____

Emergency Contact (Name, Phone # and relationship)_____

How did you hear about us:

□ Internet/Website □ Stafford Red Book □ Fredericksburg Yellow Pages □ Woodbridge/Stafford Yellow Pages

□ Welcome to the Neighborhood Mailer □ Referred by _____ □ Other _____

Previous Chiropractic Care:

□ No □ Yes (When & Where) _____

INSURANCE INFORMATION:

Do you have health insurance that you would like us to submit claims to: □ Yes □ No

If yes, please provide us with your card so that we may make a copy of it.

If your name is not on the insurance card, please fill out the information below for the person listed on the card.

Sex: □ M □ F Date of Birth: _____Soc.Sec.#: _____-_____-_____

Street Address: _____City: _____State: _____Zip:_____

Home#: _____-_____-_____

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA): □ No □ Yes. If yes, what is the remaining balance in the account: $_____

Signature of Patient/Guardian: _____Date: _____

Family Healthcare Chiropractic Center, Inc.
Dr. Thomas Genovese
261 Garrisonville Road, Ste 105; Stafford, VA 22554

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") and Dr. Thomas Genovese ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorneys' fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the HealthCare Provider by the Patient. This Assignment is to be a complete and current transfer of Patient's right, title and interest, separate from any statutory or contractual lien or claim to which the Health Care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all of the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Provider's total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patient's favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patient's attorney-in-fact any officer of the Health Care Provider, to prosecute said causes(s) of action either in Patient's name or in the Health Care Provider's name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health Care Provider's right to demand payment from the Patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patient's claim against the individual or entity whose negligence is alleged to have caused Patient's injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the HealthCare Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect of payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patient's case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of any indebtedness owed by Patient to the Health Care Provider and to negotiate same for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Witness the following signatures and seal as of the indicated date:

Patient Signature_____ (SEAL)
Printed Name_____
Date_____ SS# _____-_____-_____

Witness_____ Date _____

Health Care Provider:
_____
By: _____
Its: _____

FAMILY HEALTHCARE CHIROPRACTIC CENTER, Inc.

Your Health Profile

Why This Form Is Important

As a general focus chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Childhood (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

(Y=Yes; N=No; U=Unsure)

Did you have any childhood illnesses? ___
Did you play youth sports? ___
Did you have any surgeries? ___
Involved in any car accidents as a child? ___
Prolonged use of medicines? ___
Any other traumas (physical or emotional)? ___
Did you have any serious falls as a child? ___
Did you take/use any drugs? ___
Were you vaccinated? ___
Fallen/jumped from a height over 3 feet ___
Were you under regular chiropractic care? ___

If yes, please explain: _____

COMMENTS_____

Adulthood (18 to present)

Do/did you smoke? ___
Do/did you drink alcohol? ___
Have you been in any accidents? ___
Do/did you play adult sports? ___
Do/did you participate in extreme sports? ___
Have you had any surgeries? ___

When was your last medical physical? _____/_____/_____

Were there any concerns? ☐ No ☐ Yes (please explain):_____

COMMENTS_____

On a scale of 0 – 10 describe your stress level (0=none/10=extreme): Occupational _____ Personal _____

On a scale of Poor, Good or Excellent describe your: Diet _____Exercise_____ Sleep____ General Health____

Office Notes:

Addressing The Issues That Brought You To The Office

Briefly describe the chief area of complaint and the effect it's had on your life: _____

_____

_____

If you are experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and Goes ☐ Travels ☐ Constant

The problem is: ☐ Getting Better ☐ Getting Worse ☐ About the same

It is aggravated by:_____

It is alleviated by:_____

It interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure ☐ Other_____

Doctors seen for this problem:

☐ Chiropractor: _____ ☐ Medical Doctor: _____ ☐ Other: _____

Please check (√) any of the following that you are <u>currently experiencing or have a history of:</u>

☐ Headaches	☐ Loss of balance/dizziness	☐ Liver trouble	☐ Sinus troubles
☐ Ringing in ears	☐ Low back pain	☐ Mid-back pain	☐ Numbness
☐ Allergies	☐ Depression	☐ Heart trouble	☐ Constipation
☐ Neck pain	☐ High/Low BP	☐ Kidney trouble	☐ Asthma
☐ Menstrual trouble	☐ Fatigue	☐ Pains in legs/feet	☐ Pins/needles in arms/hands
☐ Stomach trouble	☐ Diabetes	☐ Nervousness	☐ Tight of shoulder Muscles
☐ Thyroid trouble	☐ Pain in shoulders/arms	☐ Cancer	☐ Sleeping problems
☐ Twitching of eyes	☐ Painful/swollen joints	☐ Inner tension/Irritability	☐ Pins/needles in legs/feet

COMMENTS_____

_____

_____

List any medications you are taking:_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____
Spouse: _____
Others:_____

Have you ever (Y=Yes; N=No):
Bought bottled water _____ Belonged to a health club: _____ Consumed vitamins/supplements: _____

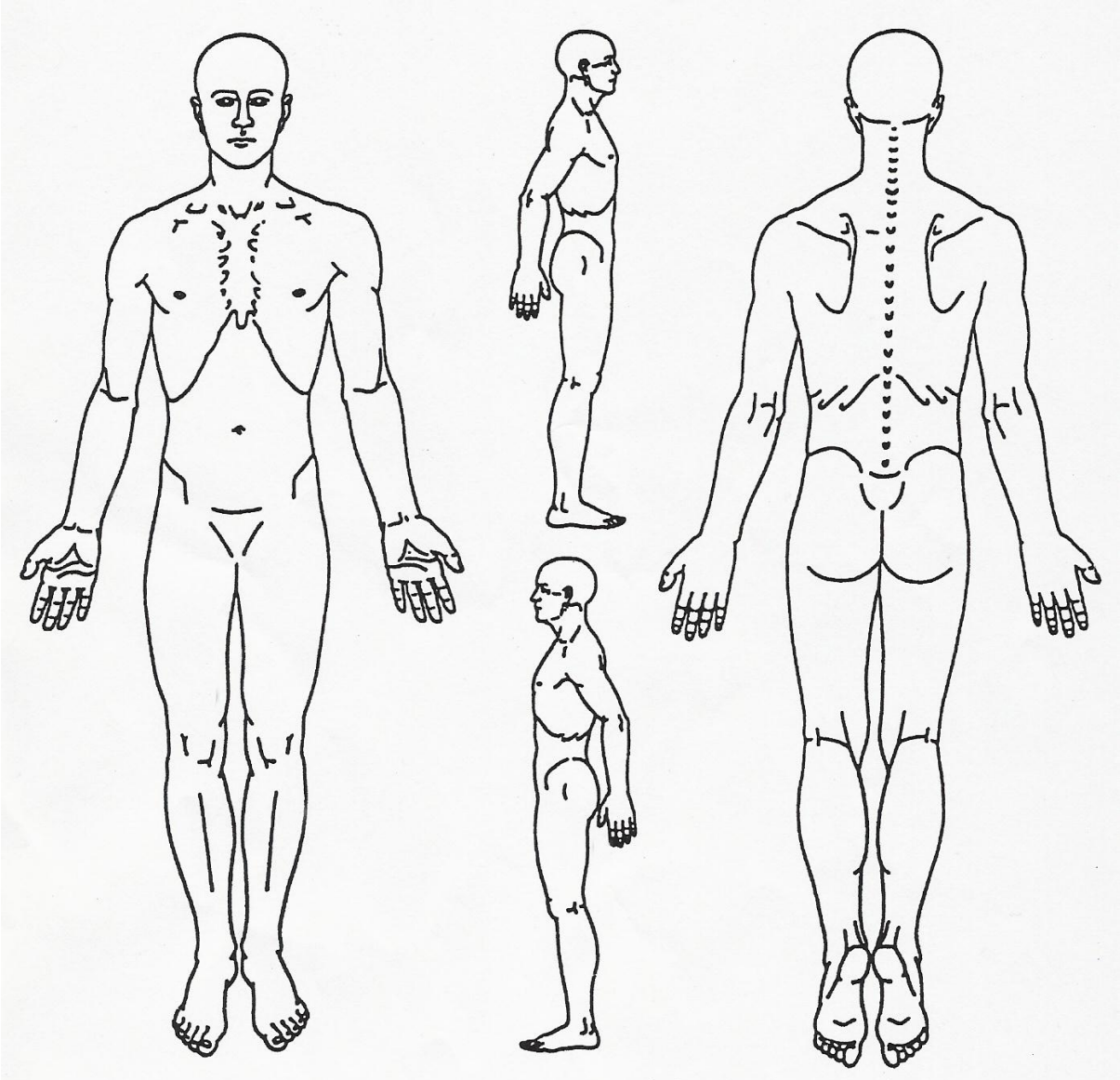
The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date: _____

PAIN DRAWING- Include all affected areas

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain.

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



FOR EACH SYMPTOM: Please indicate **ON THE DIAGRAM ABOVE** how you would rate your **PAIN**:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse pain ever)

FOR EACH SYMPTOM: Please indicate **ON THE DIAGRAM ABOVE** what percentage of the time you are awake do you experience the above symptom at the above intensity:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

FOR EACH SYMPTOM: Please indicate **ON THE DIAGRAM ABOVE** how long you have experienced these symptoms: Specify in Days, Weeks, Months or Years

PRINT NAME: _____

SIGNATURE: _____ DATE: _____