Welcome To Our Office! Please tell us who to thank for referring you to Village Family Clinic

❑Radio ❑TV ❑Facebook ❑Google Search ❑Yelp

❑Insurance Company ❑Mailer ❑Medical Doctor_____

❑Family/Friend_____ ❑Office Staff_____

Patient Identification:

Name _____ Nickname _____

Street _____ Home Phone _____

City, State, Zip _____ Cell Phone_____

Social Security # _____ Occupation _____

Date of Birth ___ / ___ / ___ Age _____ Male ❍ Female ❍

Email address _____

Contact in case of Emergency:

Name _____ Phone _____

Name of Parent of Minor Patient _____

Primary Insurance _____ **Secondary Insurance** _____

Carrier _____ Carrier _____

Active Y ❍ N ❍ Active Y ❍ N ❍

Please check any of the following that you currently or have had in the past 6 months

❑ Lose Consciousness
❑ Double Vision
❑ Slurred Speech
❑ Indigestion
❑ Difficulty Walking
❑ Nausea, Vomiting
❑ Numbness on face
❑ Visual Disturbances
❑ Arranging Words
❑ Head Pain unlike any other
❑ Pain in the Neck, jaw, face
❑ Ringing in the Ears
❑ Birth Control Pills
❑ Cancer
❑ Pain at Night
❑ Losing Weight without trying
❑ Coughing Blood
❑ Loss of Bowel/ Bladder Control
❑ Headaches for Hours

❑ Stroke
❑ Chest Pain
❑ Change in Bowel, Bladder habits
❑ Sore that does not heal
❑ Unusual Bleeding
❑ Change in your breasts
❑ Change in your warts
❑ Nagging Cough
❑ Night Sweats
❑ Drooping Eyelids
❑ Change in Pupils
❑ Prescription Medications:
  ❍ High Blood Pressure
  ❍ Blood Thinners
  ❍ Herbs/ Vitamins
  ❍ Other_____

Are you seeing any other doctor now for any reason? ❍ Yes ❍ No
If Yes, Who? _____ and For What? _____
Primary Care Physician _____ Phone _____
Any Previous surgeries ❍ Yes ❍ No,
If yes, type and Date of surgery?
Are you taking herbs, nutriceuticals, botanicals, or vitamins?
Please list _____
What was the date of onset of your last menses period? _____
Are your injuries related to any accident? ❍ Work ❍ Auto ❍ Other

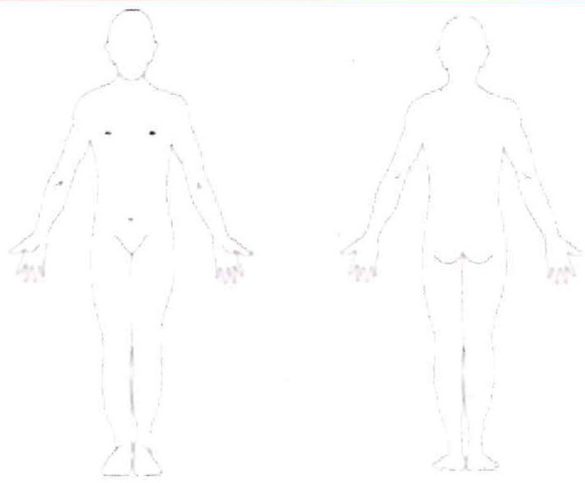
Social History

SMOKER ❍ Yes ❍ No If Yes, how many packs_____
ALCOHOL ❍ Yes ❍ No If Yes, how much _____

Family History

Did you mother or father have any of the following.
Please check: **M** for Mother, **F** for Father, and **B** for Both.

M	F	B		M	F	B	
❍	❍	❍	High Blood Pressure	❍	❍	❍	Ulcer or Stomach Problems
❍	❍	❍	Heart Attack	❍	❍	❍	Stroke - *Please indicate age when stroke occurred:* Mother _____ Father _____
❍	❍	❍	Emphysema				
❍	❍	❍	Seizure-Convulsions	❍	❍	❍	Arthritis-Rheumatism
❍	❍	❍	HIV Positive	❍	❍	❍	Mental Illness
❍	❍	❍	Asthma	❍	❍	❍	Thyroid Disease
❍	❍	❍	Diabetes	❍	❍	❍	Circulation Problems



Mark your area of Pain

Which services here are you interested in?

- ❑ Chiropractic
- ❑ DRX spinal decompression
- ❑ Nutrition Counseling
- ❑ Physical Therapy
- ❑ Cold Laser Therapy
- ❑ Acupuncture
- ❑ Orthotics
- ❑ Massage Therapy
- ❑ Other

Rate Your Pain from the Least 0  10 Most

Your Present Complaint _____

Briefly Describe your Symptoms _____
How Long has this been bothering you? _____
What other treatments have you tried? _____
How many Doctors have you seen for this? _____
Has it helped? _____ ❍ Yes ❍ No
Does your condition interfere with your sleep? ❍ Yes ❍ No
Any Activities you can no longer perform?
If yes, please describe: _____
Are you frustrated with your condition? ❍ Yes ❍ No
How has your condition negatively affected you? ❍ Work ❍ Family ❍ Activities
Have you been able to work as well as you could before? ❍ Yes ❍ No
What time of day does it bother you the most? ❍ Early AM ❍ Mid day ❍ After work ❍ Night
Are you taking any medications to deal with this? ❍ Yes ❍ No
If yes, please list: _____

I authorize and direct that payment be made directly to Village Family Chiropractic, LLC, and staff at Village Family Clinic of 1500 Rt 517 Suite 108 Hackettstown NJ 07840. For any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. I understand that I am responsible for all remaining charges. I understand and agree that Dr. James R. Fedich of Village Family Chiropractic, LLC, has the right to refuse to accept me as a patient any time before treatment begins. The taking of a history and the conducting of a physical exam are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether or not to accept me as a patient. I authorize Village Family Clinic to send my health care information to other doctors, including my primary care doctor. All unpaid balances will be subjected to a late fee and after 30 days all balances will be sent to collections. If it is necessary to assign your account to a collection agency and/or an attorney, you will be responsible for all associated fees and costs, including interest.

Signature _____ Date _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature _____ Date _____