



# Yalich Clinic & Rehabilitation Center

Crain Health Park  
331 Oak Manor Drive  
Glen Burnie, MD 21061

Welcome to the Yalich Clinics  
of Anne Arundel County!

Phone: 410-766-4878  
Fax: 410-766-6619

If you have any concerns, please feel free to inform us. We are here to support you in achieving optimum health!

## Patient Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Whom May We Thank for Referring You to Our Clinic? \_\_\_\_\_

## Emergency Contact (other than Spouse)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Current Health Condition

Please List any Major  
Symptoms or Problems \_\_\_\_\_  
You Are Experiencing: \_\_\_\_\_

When did you first notice these symptoms? \_\_\_\_\_

Are these the result of an accidental injury? \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Have you Consulted an Attorney?  
Attorney's Name: \_\_\_\_\_  
Attorney's Address: \_\_\_\_\_

Have you Consulted Another Doctor for This Condition?  
Doctor's Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_

# Health History

What Aggravates Your Condition? \_\_\_\_\_

What Relieves Your Condition? \_\_\_\_\_

Please List Any Medications You Are Currently Taking: \_\_\_\_\_

Please Provide Information and Dates of Any of These Previous Experiences:

Major Surgery / Operations: \_\_\_\_\_

Major Accidents or Falls: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Have You Had Chiropractic Care Before? \_\_\_\_\_

Doctor or Clinic Name: \_\_\_\_\_

Approximate Date of Last Treatment: \_\_\_\_\_

Have You Been Treated for Any Other Condition in the Past Year? \_\_\_\_\_

Type of Condition: \_\_\_\_\_

Have You Had Any X-Rays Recently? \_\_\_\_\_

Date of X-Ray: \_\_\_\_\_ Where? \_\_\_\_\_

Please Carefully Mark Any Condition You Have Ever Had:

Pneumonia	Mumps	Influenza	Rheumatic Fever	Small Pox
Pleurisy	Polio	Chicken Pox	Arthritis	Tuberculosis
Diabetes	Epilepsy	Whooping Cough	Cancer	Mental Disorder
Anemia	Heart	Low Back Pain	Measles	Hepatitis

Please Carefully Mark Any Condition You Had in the **Past Year**:

Poor Appetite	Excessive Thirst	Vomiting	Constipation
Liver Problems	Nausea	Diarrhea	Hemorrhoids
Abdominal Cramps	Gall Bladder	Weight Loss/Gain	Heartburn
Bloating	Dark Stool		
Bladder Problems	Painful Urination	Frequent Urination	Discolored Urine
Chest Pain	Shortness of Breath	Low Blood Pressure	High Blood Pressure
Heart Problems	Congestion	Lung Problems	Varicose Veins
Stroke	Irregular Heartbeat	Asthma	
Allergies	Vision Problems	Sore Throat	Stuffy Nose
Dental Problems	Ear Aches	Hearing Problems	Headaches
Loss of Sleep	Fever	Fatigue	TMJ
Menstrual Irregularity	Menstrual Cramping	Sexual Dysfunction	Breast Pain
Breast Lumps	Prostate Dysfunction	AIDS/HIV Positive	Vaginal Infection

Are you Currently Pregnant? \_\_\_\_\_

Date of Last Period: \_\_\_\_\_

## Affirmation

I, the undersigned, do swear that the above health information is factual to the best of my knowledge. I also agree to report any changes in name, address or other pertinent information to the clinic within two weeks of said changes.

\_\_\_\_\_  
(Signature of Patient, Parent or Legal Guardian)

## Insurance Information

### Patient's Primary Insurance

Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Policy Holder's SSN: \_\_\_\_\_

### Secondary Insurance

Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Policy Holder's SSN: \_\_\_\_\_

## Agreement

**I understand and agree that health and accident insurance policies are a contract between an insurance carrier and policyholder and that I am ultimately responsible for any services and/or treatment I receive at this clinic. I authorize this clinic to release any medical information and to complete any reports and forms to assist in collecting from my insurance company. I understand that any payments for services/treatment at the clinic will be credited to my account upon receipt of payment for said services/treatment. I further understand that delinquent accounts (over 90 days past due) are subject to interest at the rate of 1.5% per month. If my account is referred to an attorney for collection, I agree to pay an additional 15% of the balance for attorney fees. I have read and agree to the above provisions. I further certify that the above information is true and correct to the best of my knowledge and will notify you within two weeks of any changes in the information contained herein.**

**I understand the insurance verification done by this office and quoted to me as provided by my insurance representative is not a promise or guarantee of payment by my insurance carrier and I will not hold this clinic responsible for discrepancies in the benefits quoted and the benefits actually paid.**

Patient Signature: \_\_\_\_\_

(Signature of Adult or Emancipated Minor Patient)

Date: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_

(Signature of Parent, Guardian or Responsible Party)

Date: \_\_\_\_\_