



7540 Little River Turnpike Ste H
Annandale, VA 22003
Phone: 703-256-2600
Fax: 703-256-6566

PATIENT INFORMATION

DATE: _____

Name (First, MI, Last):	Preferred Name:	Date of Birth:	Age:	Sex (M/F):
Home Address/City/Zip:				
Phone Number:	Alt. Phone Number:	Email:		
Emergency Contact:	Emergency Contact Phone:	Relationship to Patient:		
Personal Physician:	Office Address/Phone:			
Pharmacy Name/City/Phone:				
How did you find our practice? (Referred, online, etc.)				

Health History

What is the main reason(s) that you would like to be seen for? _____

Are you currently under the care of another provider for a medical condition? If yes, please list:



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Past Health History

Please check the box next to any medical condition the patient currently has or has had in the past:

Seasonal Allergies	☐	Sleep Disorders (Insomnia, Apnea, etc.)	☐
Headaches (migraines, etc.)	☐	Dizziness/Vertigo	☐
Seizures	☐	Psychiatric or Emotional Illness (Anxiety, Depression, etc.)	☐
Asthma/Lung Problems	☐	Hair Loss	☐
Chest Pain	☐	Irregular Heartbeat	☐
High Blood Pressure	☐	Heart Disease	☐
Bleeding/Clotting Disorder	☐	Stroke	☐
Circulation Issues	☐	Indigestion	☐
Heartburn/Stomach Ulcers	☐	Dental Problems (TMJ, Crowns, etc.)	☐
Gastrointestinal Issues (Constipation, Diarrhea, etc.)	☐	Kidney Disease	☐
Hepatitis/Liver Disease	☐	Skin Problems (Acne, Eczema, etc.)	☐
Back Issues (Sciatica, Herniated Disc, etc.)	☐	Chronic Muscle, Tendon, or Joint Pain	☐
Chronic Pain Syndrome	☐	Diabetes	☐
Thyroid Problems (Hashimoto's, Hypothyroidism, etc.)	☐	Osteoporosis/Osteopenia	☐
Rheumatoid Arthritis	☐	Cancer	☐
Eye Problems (Glaucoma, etc.)	☐	Artificial Joints/Implants	☐
Hives	☐	Menstrual Disorders	☐
Reproductive Disorders (ED, impotence, low libido)	☐	Prostate Issues	☐
Traumatic Brain Injury	☐	Neurological Issues (Poor concentration, memory loss, etc.)	☐

Please list any additional health problems not mentioned above: _____



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Please list any significant surgeries/procedures, traumas, or accidents with approximate dates:

Current Health Information

Please list any allergies you may have (environmental, medications, foods, etc.):

Current medications/supplements you are taking, if any:

Relevant Family History (relationship/condition):

I would describe my current health status as (check all that apply): ☐ Excellent ☐ Good ☐ Poor

My physical fitness level is: ☐ Excellent ☐ Good ☐ Poor

My stress level is: ☐ High ☐ Moderate ☐ Low ☐ Manageable

My energy level is: ☐ High ☐ Moderate ☐ Low

How many meals do you eat a day? _____ How many times a week do you eat out? _____

My caffeine intake daily is: ☐ High ☐ Moderate ☐ Low

Do you currently use Tobacco, or have you used Tobacco in the past? (Y/N): _____

Onset of use (age): _____ Quit Date: _____



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Do you drink alcohol? (Y/N): _____ Approximately how many drinks a week? _____

Immunization History (check off all that apply):

DTap/Td		Gardasil	
MMR		Hepatitis A/B	
Pneumonia		Meningococcal	
Flu		Shingles	
Covid-19		Other	

Preventative Health Testing (if applicable):

Test	Month/Year	Results
Bone Density (DEXA)		
Colonoscopy		
Exercise Stress Test/EKG/Cardiac Diagnostics		
Lifeline Screening		
Coronary CT (heart scan)		

Dental History (check off all that apply):

Amalgams/Silver Fillings	
Crowns	
Root Canals	
Metal Retainers/Braces	
Implants	
Cavities	
Mouth Guard	

Women Only:

At what age did you start menstruating? _____ First day of last menstrual cycle: _____

Average days of cycle: _____

Cycles are generally (check all that apply): _____ Regular _____ Irregular _____ Nonexistent



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Date of last Pap Smear: _____ Date of last Mammogram/Thermography scan: _____

Have you ever had abnormal Pap and/or Breast Imaging results? If so, when and what was the result?

Number of pregnancies (if any): _____ Number of living children: _____ Number of miscarriages: _____

Number of vaginal deliveries: _____ Number of C-sections: _____ Did you breastfeed? (Y/N): _____

Please list any birth complications you may have had: _____

Contraceptive Method: _____

Number of years on birth control pills (if applicable): _____

Men Only:

Date of last prostate exam: _____ Date of last PSA testing: _____

Have you ever been diagnosed with an enlarged Prostate? If so, when? _____

Have you ever been diagnosed with polyps? If so, when? _____

Office Policies

All appointments require 24 hours' notice in advance for cancellations prior to appointment time. Failure to notify office staff in cases of cancellation or rescheduling prior to the 24-hour time frame will result in a **\$100 no-show fee.** **ALL APPOINTMENTS MUST BE CONFIRMED PRIOR TO THE APPOINTMENT TIME IN ORDER TO AVOID APPOINTMENT CANCELLATIONS AND FEES.** **Visits to our office will be paid when services are rendered. We accept cash, checks and most major credit cards.** Some of the services provided at Health Builders PC are covered under standard insurance policies. Dr. Kim and Dr. Fuller are out-of-network providers, so out-of-network benefits apply once the applicable deductible has been met. **We welcome Medicare patients for Dr. Fuller only.** Dr. Fuller patients may pay a discounted rate for Medicare and all charges will be electronically submitted. We will file your charges and any Medicare payments will be mailed to you. Medicare provides reimbursement for qualified charges of manipulation. There is no reimbursement for acupuncture or other physiotherapy. For charges that may



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not be covered by Medicare, we may ask you to sign an ABN (Advanced Beneficiary Notice). **Dr. Kim is completely opted out of Medicare.**

Health Builders employ diagnostic and treatment methods that are traditional and nontraditional. Because we look for imbalances in the body and for trends that may result in illness if not addressed (a preventive approach), we may order tests not considered by insurance to be 'necessary' or standard of care. **We employ diagnostic tools and treatment modalities that include but are not limited to chiropractic, acupuncture, electrodermal testing (Asyra), muscle testing (NRT), Neuro-emotional Technique (NET), Neural therapy, Emotional Freedom Technique (EFT), intravenous vitamin therapy, nutritional supplements, homeopathy, and herbal therapies. By signing this, consent is given for the above modalities as it pertains to my office visits.**

I have completed the above information as accurately as possible and to the best of my knowledge. I have read the Privacy Policy as mandated by HIPAA and have received a copy. I authorize treatment by Drs. Fuller and Kim with the understanding that there are no guarantees or claims that I will be helped by undergoing treatment here. I understand the collaborative nature of entering into a health agreement with my providers whose goal is to assist me in optimizing my health.

Patient Name (Print): _____

Patient Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of our patients and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practice.

AUTHORIZATIONS:

- A. I hereby authorize release of any medical information necessary to process a claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged



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directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient Name (print): _____

Patient/Guardian Signature: _____

Date: _____

Credit Card Authorization Form

A valid credit or debit card MUST be kept on file to save all New Patient appointments. Payment will not be made at the time of scheduling, but it is required to hold the appointment for the patient.

The card on file may NOT be an HSA or FSA card.

Patient's Name: _____ Name on Card: _____

Credit Card # _____

Exp: ____/____/____ CVV _____ Zip Code Associated with card: _____

I, _____, authorize Health Builders, PC to keep my credit card on file and bill by credit card for cancellation fees, payment of services, laboratory fees and supplements as needed.

Explanation of Payment and Cancellation Policy

Payment is due at the time of service. We are an out-of-network provider, meaning we do not accept any insurance for payment for services. It is necessary to cancel your scheduled appointment at least 24 hours in advance to avoid cancellation/fees. **The card will not be charged unless the patient cancels after 24 hours prior to the appointment time, "no-shows", or does not confirm via email, text message, or phone call prior to the appointment. Our scheduling system sends automatic reminders to confirm appointments beforehand via email and text message.** You may request to void this authorization after the initial visit to remove the payment information from your chart. Otherwise, the card on file will only be used for cancellation fees or if otherwise authorized by the cardholder.