

PATIENT INTRODUCTION

Please answer the following questions completely

Name: _____ SS# _____

Address: _____ Apt# _____ City: _____ State: _____ Zip code: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

E-mail address: _____

Employer: _____ Occupation: _____

Sex: M F Marital Status: S M D W Age: _____ Date of Birth: ____/____/____

Are you interested in: **Chiropractic Service, Spinal Decompression, Laser Therapy, or All of the above**

Do you have health insurance? (Out of Network Benefits) Yes No

Have you had a recent neck or back MRI? Yes No

Is it possible you are Pregnant? Yes No

Reason for Visit: _____

Are you here because of: An auto accident? Date Injured: ____/____/____
 An on-the-job injury? Do you have an Attorney? Yes No
 Slip and Fall

Please list all accidents, falls, injuries, surgeries, and major illnesses

TYPE	DATE	DESCRIBE / COMMENTS

Are you presently taking any medications?

NAME OF DRUG		DESCRIBE / COMMENTS

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Heart Pain | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Palpation | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Sinus pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Anemia | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Tightness in throat | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Inflammation in throat | <input type="checkbox"/> Tight shoulder muscles | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Neuritis arms/shoulders | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Pins & needles | <input type="checkbox"/> Nerves & nervousness | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Arms/hand pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pinched nerve |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Irregular sleep |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Leg/feet pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Neck pain |

PLEASE CONTINUE ON THE BACK

Payment/Insurance Information

Please complete all applicable information

How did you hear about our office: Facebook Google Instagram
 Other: _____

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED. AS A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU.

- **Cash/Check/Credit Card:** Payment is due in full when services are rendered. We accept Visa, Master card, American Express, and Discover card for payment.
- **Insurance:** We will file your medical insurance for you. We must have a copy of your health insurance card as well as your driver's license for your file. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.
- **Automobile Insurance:** We must have verification of insurance, a copy of your insurance card, a copy of your driver's license, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.
- **Workers Compensation:** Authorization for treatment must be in writing from your employer. If this is not possible on the first visit, we will accept verbal authorization until authorization can be obtained in writing.

I authorize the release of any information pertinent to my case to any insurance company or adjuster for the purpose of obtaining payment for my bills.

Signature: _____

I further authorize and direct the _____ Insurance Company to pay North Atlanta Chiropractic Center directly for services rendered to me.

Signature: _____ Date: ____/____/____

I authorize North Atlanta Chiropractic Center to take photographs/videos of me and to use my name in connection with these images for medical documentation, treatment records, and marketing.
(I understand that once my images are used publicly, they may be shared or reproduced by others outside the control of North Atlanta Chiropractic Center.)

Please **Initial** one:

_____ I authorize the use of my images for marketing or promotional purposes

_____ I do **NOT** authorize the use of my images for marketing or promotional purposes

****A surcharge of 4% on the transaction amount will be added for all Credit/Debit card products.****

I _____, have read the above and checked one method of payment. I have agreed that the unpaid balance is my responsibility and will pay any balance that has gone unpaid over 60 days.

Patient Signature: _____

Witness: _____

Date: ____/____/____