Intelligent Chiropractic

Confidential Patient Information

(IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST)

_____
Today's Date

Name: _____
Last Name First Name Middle Initial

Nick Name: _____ Date Of Birth: _____

Marital Status: Married Single Divorced Separated Other: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone: _____ Work: _____ Cell: _____

Social Security: _____ Age: _____ Gender: _____

Name of Spouse/Relative: _____ Phone: _____

Your Occupation: _____ Your Employer: _____

How Did You Hear Of Our Office: _____

If You Were Referred, Who May We Thank? _____

May We Use Your Name When Thanking This Person? Yes No

1100 Hammond Dr. Ste 220, Atlanta, GA 30328
(404) 531-9525 (voice) - (404) 531-9842 (fax)

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Please Describe Present Major Complaints

Please Rate Your Symptoms From 1-10 With 1 Being The Least Serious.

Description	Strength of Pain & Radiation (if applicable)	Rating

Symptoms Developed From: __Auto Accident __Job-Related Injury __Sports Injury __Slip/Fall __Illness __Gradual Onset __Unknown Cause

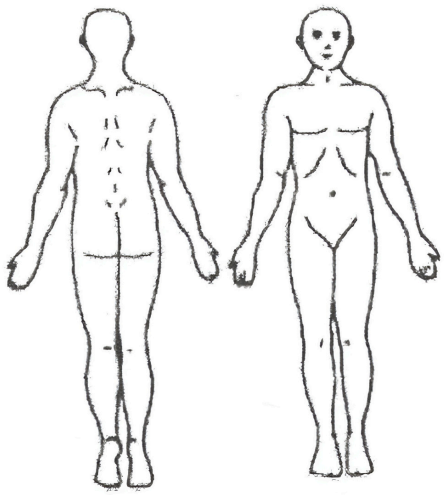
Date Occurred:_____

Symptoms Persisted For:___Hours ___Day(s) ___Week(s) ___Month(s) ___Year(s)

Have You Ever Suffered With This Before? ☐No ☐Yes If Yes, When?_____

Please Indicate TYPE and LOCATION of Current Sensation

A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing



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Current Health Conditions and Symptoms Status

Symptoms/Complaints: ☐ Come and Go ☐ Almost Always Contstant ☐ Contstant

Symptoms Are Worse In: ☐ Morming ☐ Afternoon ☐ Contstant

Do You Suspect Or Curently Pregnant? ☐ Yes ☐ No

Pecent of your Day Spent Sitting:_____%

Name and Location of Doctors Previously Seen for Present Condition(s):

_____

_____

Are You Currently Taking Any Medications: (Please Circle) Yes or No. If Yes, Please List Below:

_____

_____

Please Check the Activities Below That Aggravate Your Condition:

___Bending
___Getting Up & Down
___Overhead Activities
___Lifting
___Coughing
___Sneezing
___Turning Head
___Driving
___Standing
___Sitting
___Lying Down
___Walking
___Exercising
___Increased Activity
___Preparing Food
___Straining To Stool

Please Check the Activities Below That Relieve Your Condition:

___Heat
___Ice
___Medication
___Lying Down
___Sitting
___Standing
___Stretching (including head & neck)
___Reaching
___Lifting
___Resting
___Walking
___Bending

Please Check **Any Additional Symptoms** You May Be Experiencing:

___Blurred Vision
___Buzzing in Ears
___Cold Feet
___Cold Hands
___Cold Sweats
___Concentration Loss
___Depression/Weeping Spells
___Flushed Face
___Constipation
___Diarrhea
___Dizziness
___Fainting
___Fatigue
___Fever
___Heavy Head
___Headaches
___Insomnia
___Light Sensitivity
___Loss of Balance
___Loss of Smell
___Loss of Taste
___Low Resistence to Colds
___Muscle Jerking
___Numbness in Fingers
___Numbness in Toes
___Pins & Needles Arms
___Pins & Needles Legs
___Ringing in Ears
___Shortness in Breath
___Stiff Neck
___Upset Stomach
___**None**

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MEDICAL/FAMILY HISTORY

Key: S = Self, M = Mother, F = Father

(Please indicate which PAST conditions have been experienced PRIOR to present complaint by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	nervous
❑	❑	❑	allergies	❑	❑	❑	epilepsy	❑	❑	❑	NONE stated
❑	❑	❑	anemia	❑	❑	❑	fibromyalgia	❑	❑	❑	numbness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	osteoporosis
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	hepatitis	❑	❑	❑	reproductive disorder
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	high cholesterol	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	HIV/ARC	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	is deceased	❑	❑	❑	scoliosis
❑	❑	❑	constipation	❑	❑	❑	kidney disorder	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	bowel control loss	❑	❑	❑	sinus troubles
❑	❑	❑	deceased	❑	❑	❑	lung disease	❑	❑	❑	stroke
❑	❑	❑	depression	❑	❑	❑	menstrual cramps	❑	❑	❑	thyroid problems
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	diarrhea	❑	❑	❑	muscular dystrophy	❑	❑	❑	ulcers
❑	❑	❑	indigestion	❑	❑	❑	neck pain	❑	❑	❑	STD

Date of Last Physical Exam: _____

Have you been treated by a physician for any health condition in the last year? □ Yes □ No

If yes, describe the condition: _____

Have you ever had a metal implant? □ Yes ☐ No Ever been shot by a gun? □ Yes ☐ No

SURGICAL HISTORY:

1. _____ Date _____

2. _____ Date _____

ACCIDENT HISTORY: :

Job □ Auto □ Other 1. _____ Date _____

Job □ Auto □ Other 2. _____ Date _____

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Assignment And Instruction For Direct Payment To My Doctor

Patient Name (Please Print)_____

Date of Accident or Onset:_____

Claim or Group #:_____

I hereby instruct and direct my insurance company to pay by check make out and mailed directly to:

Intelligent Chiropractic LLC
1100 Hammond Dr. Ste 220
Atlanta, Georgia 30328

If my current policy prohibits straight payment to my doctor, then I hereby authorize and instruct a check to be made payable and sent by mail to:

Intelligent Chiropractic LLC
1100 Hammond Dr. Ste 220
Atlanta, Georgia 30328

The professional or medical expense benefits are allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in an expeditious manner, any balance of said professional services or charges over and above this payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information relevant to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____

Signature of Policyholder or Claimant Date

Intelligent Chiropractic

Consent To Treat

When a patient seeks chiropractic health care and we adept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: Misalignment of one or more of the 24 vertebrae in the spinal column can alter nerve function and interfere with the transmission of mental impulses, ultimately diminishing the body's innate ability to achieve its full health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I _____ have read and fully understand the above statements.
Patient Name (Please Print)

I have answered all questions about the doctor's objectives for my care in this office to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

_____ _____
Signature Date

Consent To Evaluate And Adjust A Minor Child

I _____ being the parent or legal guardian of

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant, and the above doctor and his/her associates have my permission to perform an X-ray evaluation. I have been advised that X-rays can be hazardous to an unborn child. Date of last menstrual period:_____

_____ _____
Signature Date

Intelligent Chiropractic

Consent To Treat

My signature acknowledges receipt of the services and gives my consent to receive treatment. I further authorize the above-named doctor or clinic any and all benefits due as a result of the treatment provided. I am aware that I am personally responsible for charges and/or balances not covered by my insurance carrier. I hereby state and agree that a photocopy of this statement will be deemed valid and binding on all parties involved as the original copy.

Attention Medicare Patients: In accordance with the Medicare Act, Section 1862(a)(1), this letter is to advise you that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(a)(1) of the Medicare Act. If Medicare determines that a particular service, although normally covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for the services rendered. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient Name (Please Print)

Parent or Authorized Representative (if applicable)

Patient/Authorized Signature

Date

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Policies

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary.

3. Method of payment you plan to use to take care of today's charges?

☐ Cash ☐ Check ☐ Credit Card (All Major Cards Accepted)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand Intelligent Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Intelligent Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that any outstanding charges for professional services rendered will be immediately due and payable if I suspend or terminate my care at this office. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Intelligent Chiropractic to obtain a credit report if deemed necessary.

We require a minimum of 24 hours advance notice to cancel an appointment. By not canceling in advance, you are denying others health care. We reserve the right to charge the full fee of $25.00 for all missed appointments not canceled with 24 hours notice. Insurance companies will not reimburse you for missed visits. Therefore, this will be your sole responsibility.

Patient Signature

Date

Guardian Signature Authorizing Care

Date

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Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (Please Print)

Date

Parent or Authorized Representative (if applicable)

Signature

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