Scott Chiropractic Center
2151 Fountain Drive Ste 103, Snellville, Georgia 30078-2919
Phone: 770-972-9160 Fax: 770-978-1699

PATIENT INFORMATION

Please provide us with your legal name.

Name:_____ Date of Birth: _____ Sex □M □F
FIRST LAST MI

Address:_____
STREET CITY ZIP

□Home Phone: (____)-_____□ Cell: (____)-_____ □ Work: (____)-_____

Cell phone Carrier:_____ E-mail:_____

Occupation:_____ Employer:_____

Social Security Number: _____ Marital Status: _____ Children: _____

Name of Spouse:_____ Spouse Date of Birth _____

Name and phone of nearest relative not living with you:_____

Previous Chiropractic Care: □Yes □No If so, where?_____

Referred by:_____

PATIENT QUESTIONNARE

Please take your time and fill out completely.

What is your chief complaint? _____

How long have you had this condition? _____

Is this condition due to injury arising out of employment? □ Yes □ No

If Yes, Number of days lost from work _____ Date symptoms appeared: _____

Is this condition due to an auto or other accident? □ Yes □ No Date of accident: _____

If this is a recurrence, when was the first time you noticed this problem?_____

How did it originally occur? _____

What other doctor have you seen for this condition? _____

Has it become worse recently? □ Yes □ No □ Same □ Better □ Gradually □ Worse

How frequent is the condition? □ Constant □ Daily □ Intermittent □ Night Only

How long does it last? □ All day □ Few Hours □ Minutes

Are there any other conditions or symptoms that may be related to your major symptom? □ Yes □ No

If yes, describe_____

Are there any other unrelated health problems? □ Yes □ No

If yes, describe_____

Describe the pain: □ Sharp □ Dull □ Numbness □ Tingling □ Aching □ Burning □Stabbing □ Other____

Is there anything you can do to relieve the problem? □ Yes □ No

If yes, describe _____

What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting □ Other

Have you had any broken bones? □ No □Yes

If yes,

describe_____

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_____ _____
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List any major accidents you have had other than those that might be mentioned above:

_____

WOMEN ONLY: Is there any possibility that you are or may be pregnant? □ Yes □ No □ Uncertain

Other remarks concerning your condition that was not asked for in the questions above:

_____

Please indicate your level of problem with 0 being no symptoms and 10 being extreme symptoms.

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

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

If yes, please describe: _____

Date of last physical examination: ___ / ___ / _____

Height:_____

Weight:_____

Smoking Status:

□ Current Smoker Number of years smoked:_____

□ Former Smoker Number of years since quitting:_____

□ Never Smoked

Current Medications/Supplements:

□ No Current Medication

□ Current Medication (please list amounts and frequency medication is consumed)

_____

_____

What operations have you had? (Tell when)_____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form, either in the past or present? □ Yes □ No Describe: _____

Do you have or have you ever suffered from:

□ Dizziness	□ Arthritis	□ Digestive Disorders	□ Cancer
□ Backaches	□ Headaches	□ Nervousness	□ Hernia
□ Heart Trouble	□ Numbness	□ Sinus Trouble	□ Neuritis
□ Diabetes	□ Asthma	□ Anemia	□ Rheumatic Fever

Current Allergies:

□ No Allergies

□ Allergies (please list allergies below)

_____

_____

Patient/Guardian Signature: _____ Date:_____

_____ _____

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SIGNATURE ON FILE

√ I understand that I am responsible for the portion of my bill that insurance does not cover.

√ I authorize use of this form on all my insurance submissions.

√ I authorize release of my information to all my insurance companies.

√ I authorize my doctor's office to act as my agent in helping me obtain payment from my insurance companies.

√ I authorize direct payment to my doctor from my insurance companies.

√ I understand that the doctor is not responsible for arising problems if I am not compliant with all instructions and recommended care plans and/or treatments.

√ I understand that all my records are kept confidential, with the exception of those necessary for collection or insurance billing purposes. I also permit a copy of this authorization to be used in place of the original.

Patient/Guardian Signature: _____ Date:_____

CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent to the performance of examination and treatment on me by the licensed doctors of chiropractic, medical doctors and/or licensed physical therapists who may be employed by or engaged in practice at this clinic.

I will have an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to factures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient/Guardian Signature: _____ Date:_____

_____ _____
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X-RAY CONSENT FORM

I hereby authorize a diagnostic x-ray examination which Scott Chiropractic Center, P.C. may consider necessary or advisable in the course of examination or treatment. I understand that there is a fee for this service, which I am responsible for at the time of services and rendered unless prior arrangements have been made.

□Yes, I consent to have x-rays taken.

Female Only:

□ No, I am not pregnant. □ Yes, I am pregnant.

Patient/Parent Signature_____ Date_____

Witness Signature_____ Date_____

INSURANCE:

√ If you have Medicare and a secondary insurance, you are responsible for notifying Medicare about the secondary coverage. We DO NOT file secondary insurance because Medicare forwards your claims automatically.

√ WE ONLY BILL PRIMARY INSURANCE. You are responsible for filing your secondary and submitting payment to us in the event that payment is made directly to you.

√ I understand and agree that I will be responsible for any balance not covered by insurance.

√ I understand that there is a $35 fee for returned checks.

I have completed this form accurately, truthfully, and completely. I certify that I am the patient or authorized guardian. If mine is regular health insurance case, I agree to pay a percentage of services or my co-pay at the time services are rendered. However, I understand that I am ultimately responsible for payment in full to this office should insurance be denied. If I suspend or terminate my care prematurely, any fees remaining will be immediately due to this office. I also understand and agree that health and accident insurance policies are an arrangement between the company and me - not this office. I authorize this office to release any medical information and to complete any usual reports/forms at no charge, in order to assist in collecting monies from my insurance company.

Patient/Parent Signature_____ Date_____

Witness Signature_____ Date_____

_____ _____
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