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 QUESTIONNAIRE

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

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Have you had any broken bones? □ Yes □ No

If yes, describe______________________________

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: ___ / ___ / _____

What medications/supplements are you currently taking? ______________________________

____

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

Patient/Guardian Signature: ______________________________ Date:_________________

Please check the options that apply to you:

- □ I am interested in symptom relief care and corrective care to maintain spinal health and prevent degenerative disease.
- □ I am only interested in symptom relief care.
- □ I feel good. I want to include chiropractic care into my wellness regimen so I can stay active.
- □ I would like to schedule an appointment for my family members for a spinal check up.

I would like to speak with the doctor about my interest in:

- □ Nutrition Consultation and Supplements
- □ Detoxification – Inner Body Cleansing
- □ Weight Loss
- □ Custom Shoe Inserts/Orthotics

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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/massage 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______________

PERSONAL INJURY

Welcome to Scott Chiropractic Center! We are here to help you return to excellent health. If you have any questions or need any information, don't hesitate to ask our staff.

In an effort as to not cause any confusion as to who is paying for your care, we request a copy of your MedPay limits listed on your Declaration Page from your Automobile Policy or a letter from you insurance carrier stating the limits.

Required Information for a Personal Injury

Claim Number: ____

Adjuster Name: ____

Adjuster Contact Number: ____________________________________

MedPay Limits: ____

Group insurance will not process your claim unless there are no MedPay limits available on your car insurance. In addition, we request a letter from your car insurance stating if there are no MedPay limits.

If the following information is not received within reasonable time, we will move forward on a cash basis.

DIRECT PAYMENT

I hereby instruct and direct the ______________________________ Insurance Company to pay by check and mailed directly to:

Scott Chiropractic Center, P.C.
2151 Fountain Drive Ste 103
Snellville, Georgia 30078

Or if my current policy prohibits direct payment to doctors, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Scott Chiropractic Center, P.C.
2151 Fountain Drive Ste 103
Snellville, Georgia 30078

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed by indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment that may be due.

Patient/Parent Signature____ Date______________

Witness Signature____ Date______________

____________________________________ PATIENT NAME ______________ PATIENT NUMBER

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RELEASE OF MEDICAL RECORDS

Name of Injured Person:____ Date of Birth:______________________

Social Security Number:____ Date of Accident:__________________

Insurance Company:____ Claim Number:_____________________

I authorize the disclosure of protected information from:

Scott Chiropractic Center
2151 Fountain Drive Ste 103
Snellville, Georgia 30078

I hereby authorize the release of confidential information including medical healthcare records, but is not limited to the following:

√ History
√ Treatment Records
√ Diagnosis
√ Prognosis
√ Narrative Reports
√ Billing Records

This authorization also permits my medical provider to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and any other information.

Scott Chiropractic Center is authorized to release the information to:

____

PATIENTS INSURANCE COMPANY

____

ADDRESS

____

I have the right to revoke this authorization in writing at anytime, except if information has already been released to the company listed above.

Patient Signature: ____ Date: _______________

____ _______________

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MOTOR VECHICLE COLLISION QUESTIONNAIRE

Please answer all questions completely.

Name:____ Date of Birth: _______________ Sex □M □F

FIRST LAST MI

Address: ____

Please describe the collision in your own words:

____

____

____

Where did the collision occur? City: ______________________________, State:_____________________

Date of collision: ___/___/_____ Time of collision: ____:____ □AM □PM

Were you the □ Driver □Passenger □Pedestrian

If passenger: were you in the □ Front Seat □ Right Rear Seat □Left Rear Seat

What type of vehicle were you in? ____

What type was the other vehicle? ____

Did your vehicle strike the other vehicle? □ Yes □ No

Was your car struck by the other vehicle? □ Yes □ No

What direction was your vehicle going? ____

What direction was the other vehicle going? ____

Was the impact from the: □ Front □ Rear □ Left Side □ Right Side

What was the approximate speed at the time of impact?

Your Vehicle ____mph Other Vehicle ____mph

What was the weather at the time of the collision? □ Dry □ Wet □ Icy

Was your vehicle in? □ Park □ Neutral □ In Gear □ Moving □ Stopped

Were your brakes being applied? □ Yes □ No

Was your vehicle shoved? □ Forward □ Backward □ Sideways

Were you shoved? □ Forward □ Whipped Backward

Did your seat have a head restraint (headrest)? □ Yes □ No

If Yes, what was the position? □ Low □ Mid-position □High

Did your head ride over the headrest? □ Yes □ No

Did your hat/glasses end up in the back seat or rear window? □ Yes □ No

Did any other part of your body hit the interior of the vehicle? □ Yes □ No

If Yes, please specify: □ Seatbelt Restraints □ Steering Wheel □ Dashboard □ Side Door □ Side Window □ Other: ______________

Which part of your body? □ Chest □ Head □ Chin □ Face □ R L Knee □ R L Shoulder □ R L Hand □ Other: _______________

Were you holding on to the steering wheel? □ Yes □ No

Did you brace your arms against the dash? □ Yes □ No

Did you brace your legs against the floorboard? □ Yes □ No

Was your ankle turned? □ Yes □ No

_______________________________________ ______________

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QUESTIONNAIRE CONTINUED

Did your vehicle go into a spin or roll as a result of the impact? □ Yes □ No

If Yes, explain: ______________________________

How much damage was there to the outside of the vehicle? □ None □ Some □ A lot

How much damage was there to the inside of the vehicle? □ None □ Some □ A lot

At the point of impact, where did you experience pain? Be specific: ______________________________

____

Immediately after the accident were you: □ Conscious □ Dazed □ Unconscious

If you lost consciousness, how long: ______________________________

Were you wearing your seatbelt? □ Yes □ No

Did the belt have a shoulder harness? □ Yes □ No

If Yes, did it contribute to the pain you are experiencing? □ Yes □ No

At the time of impact were you: □ Looking straight ahead □ Looking to the right □Looking to the left □ Looking down □Looking up

Did the seat break as a result of the impact? □ Yes □ No

Were you braced for the impact? □ Yes □ No

Were you surprised by the impact? □ Yes □ No

Did you go to the hospital? □ Yes □ No

If Yes, when? □ Right after the accident □ Next day □ Other: ______________________________

If Yes, how did you get there? □ Ambulance □ Other: ______________________________

If by ambulance, did the ambulance attendant place you in: □ Neck Brace □ Back Brace □ Other: ___

Any medication or medical supplies given? □ Yes □ No □ Explain: ______________________________

Did you have x-rays taken at the hospital? □ Yes □ No

If you went to the hospital, please answer the following?

Name of Hospital: ______________________________

Name of Doctor: ______________________________

Diagnosis: ______________________________

Treatment Received: ______________________________

Have you has any similar problems before? □ Yes □ No

If Yes, explain: ______________________________

Are you diabetic? □ Yes □ No

Do you have high blood pressure? □ Yes □ No

Did you have low blood pressure? □ Yes □ No

Do you have arthritis or degenerative joint disease? □ Yes □ No

What type of work do you do? What are your requirements? ______________________________

Have you lost any days of work from this injury? □ Yes □ No

If Yes, give dates: ______________________________

Patient/Parent Signature______________________________ Date ______________

______________________________ PATIENT NAME ______________ PATIENT NUMBER