

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

Address: _____
FIRST LAST MI 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:

- | | | | |
|--|------------------------------------|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> 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 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 fractures, 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: _____

PATIENT NAME

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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 _____

PATIENT NAME

PATIENT NUMBER

WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completely.

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

Address: _____

Phone Number: _____ Occupation: _____

Employer's Name: _____

Address: _____

Phone Number: _____ Type of Business: _____

Workers Compensation Insurance Carrier: _____

Date of injury: ___/___/___ Time of injury: ___:___ AM PM

Address of where you were injured: _____

Did you notify your employer of this injury? Yes No

Have you retained and attorney? Yes No

If Yes, Name and Address: _____

Are you currently in litigation for this injury Yes No Maybe

Please explain how the injury occurred: _____

What injuries did you suffer? _____

What was the last day you worked? ___/___/___ When did you return to work? ___/___/___

When was your first examination? ___/___/___

Who examined you? _____ D.C. M.D. D.O. D.D.S.

What was doctor's diagnosis? _____

Have you received any treatments prior to visiting this office? Yes No

What treatments did you receive? _____

Have you ever injured this area before? Yes No

If Yes, when did the injury occur? ___/___/___ Did you lose time from work? Yes No

If you lost time from work with injuries prior to this injury, please list doctors consulted: _____

Do you have other injuries or illnesses that affect your employment? Yes No

If Yes, explain: _____

In your work, do you favor one part of your body more than others? Yes No

If Yes, explain: _____

Do you have a history of absenteeism caused from accidents on the job? Yes No

Have you ever had a Worker's Compensation claim before? Yes No

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are you work activities restricted as a result of this accident? Yes No

Since this injury are your symptoms: Improving Getting Worse The Same

Patient/Parent Signature _____ Date _____

PATIENT NAME

PATIENT NUMBER

WORKER'S COMPENSATION AUTHORIZATION

Patient Name: _____

Date of Accident: ___/___/_____

Disability: Date last worked? ___/___/_____ Date returned to work? ___/___/_____

Employer: Name: _____

Address: _____

Phone: _____

Contact: _____

Worker's Compensation Carrier:

Name: _____

Address: _____

Phone: _____

Contact: _____

Do you wish billing to be forwarded to employer or insurance carrier?

Employer

Insurance Carrier

The above patient has advised me of his work-related injury and that he/she is being treated by:

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Signature Authorized Representative: _____ Date _____

Please Print Name: _____

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