What to bring to your first visit:

*Identification (drivers license)
*Health Insurance Card
*X-Rays (if taken since injury)
*Police Report (auto accident)
*Auto Insurance Card (yours **and** the drivers, if you were a passenger)

Riverdale: at the intersection of Highway 138 and Route 314 in Crossroads Plaza.
click here for directions
1807 Highway 138 SW
Riverdale, GA 30296
770-997-7000

McDonough: 1/2 mile east of I-75, off Hampton-McDonough Road (exit 218) on Regency Way in the Magnolia Office Pavilion.
click here for directions
902 Pavilion Way
McDonough, GA 30253
678-583-9583

We look forward to seeing you!

PERSONAL INFORMATION

Name: _____ Social Security # _____-_____-_____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: (___) _____. Birth Date: _____Age:____ Sex: ☐ M ☐ F

Cell Phone: (____) _____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Driver's License No. _____ State_____ Expires_____

Employer Name: _____ Work Phone: (___) _____.

Address: _____ City: _____State: _____ Zip:_____

Name of Spouse: _____ Spouse's Social Security # _____-_____-_____

Spouse's Employer Name: _____ Work Phone: (___)_____

Address: _____ City: _____State: _____ Zip: _____

Name of Emergency Contact: _____

Relationship: _____Phone # _____

INSURANCE INFORMATION (Please submit your card(s) and drivers license to be copied)

PRIMARY MEDICAL

Insurance Co:_____

Policy Number:_____ Group Number: _____

Policy Holder:_____ Policy Holders Social Security # _____-_____-_____

Policy Holders Employer_____

SECONDARY MEDICAL

Insurance Co:_____

Policy Number:_____ Group Number: _____

Policy Holder:_____ Policy Holders Social Security # _____-_____-_____

Policy Holders Employer_____

IF THIS WAS DUE TO AN AUTO ACCIDENT

Auto Insurance Carrier:_____ Policy Number: _____

Attorney Firm: _____ Contact Name _____

Address: _____

City: _____State: _____ Zip: _____ Phone: (___) _____.

Assignment of Benefit/Consent for Treatment: I do hereby assign all medical and/or chiropractic benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I authorize this office to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means; to any insurance company, adjuster or attorney. I hereby voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending doctor. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

PATIENT SIGNATURE: _____ **DATE:**_____

GUARDIAN SIGNATURE: _____ **DATE:** _____

CURRENT HEALTH CONDITION

NAME: _____ **DATE:** _____.

Primary Complaint: _____

How would you describe the pain? (check all which apply)

☐ Dull ☐ Sharp ☐ Burning ☐ Stabbing ☐ Shooting ☐ Throbbing ☐ Stiff ☐ Aching ☐ Heavy ☐ Other_____

How would you rate severity of the pain?

☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Secondary Complaint: _____

How would you describe the pain? (check all which apply)

☐ Dull ☐ Sharp ☐ Burning ☐ Stabbing ☐ Shooting ☐ Throbbing ☐ Stiff ☐ Aching ☐ Heavy ☐ Other_____

How would you rate severity of the pain?

☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU CURRENTLY HAVE:

☐ **Neck:**
☐ Stiff ☐ Pain
☐ **Shoulder Pain**
☐ Left ☐ Right ☐ Both
☐ **Arm Pain**
☐ Left ☐ Right ☐ Both
☐ **Arm-Hand Numbness or Tingling**
☐ Left ☐ Right ☐ Both
☐ **Muscle spasm in Neck/Shoulders**

☐ **Headaches:**
☐ Constant ☐ Episodic
☐ Sharp ☐ Dull
☐ Aching ☐ Throbbing
☐ Dizzy ☐ Light-headed
☐ Nausea ☐ Vomiting
☐ Fainting ☐ Forgetfulness ☐ Ringing in the ears ☐ Blurred vision

How Would you Rate the Headaches?
☐ Mild ☐ Mod ☐ Severe

☐ **Mid-Back:**
☐ Stiff ☐ Pain
☐ **Pain Between Shoulders**
☐ **Chest-Rib Pain**
☐ **Shortness of Breath**
☐ **Muscle spasm in Mid-Back**
☐ **Tension**

General:
☐ **Sleeping problems**
☐ **Nervousness**
☐ **Fatigue**
☐ **Irritability**
☐ **Depression**
☐ **Excessive Thirst**
☐ **Difficult Chewing / Clicking Jaw**
☐ **Stomach pain**
☐ **Poor / Excessive Appetite**

Other Problems
☐ _____
☐ _____

☐ **Low-back:**
☐ Stiff ☐ Pain
☐ **Leg Pain**
☐ Left ☐ Right ☐ Both
☐ **Leg Numbness or Tingling**
☐ Left ☐ Right ☐ Both
☐ **Foot Numbness or Tingling**
☐ Left ☐ Right ☐ Both
☐ **Muscle spasm in Low-Back**
☐ **Buttock Pain/Sore**
☐ **Abdominal Cramps / Upset Stomach**
☐ **Excessive Gas / Flatulence**
☐ **Constipation**
☐ **Diarrhea**
☐ **Black / Bloody Stool**
☐ **Discolored Urine**

FEMALES ONLY:
☐ **Pregnant?**
☐ Yes ☐ No ☐ Not Sure
Date of Last Menstrual Period _____
Number of Children: _____

When Did This Condition Begin? _____

Have You Seen Other Doctors For This Condition: ☐ Yes ☐ No **Who?** _____

Drugs You Taking for <u>THIS</u> condition:

☐ Pain Killers ☐ Anti-inflammatory ☐ Muscle Relaxer ☐ Nerve Pills ☐ Other _____

Is This Condition Due to:

☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

If Job Related Have You Made a Report of Your Accident To Your Employer? ☐ Yes ☐ No

Occupation / Type of Work: _____

Work Activities: ☐ Sitting ☐ Standing ☐ Bending ☐ Stooping ☐ Twisting ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

Exercise / Activities: ☐ None ☐ Moderate Activity (2-3x / week) ☐ Heavy Activity (4-7x / week) ☐ Weight Training ☐ High impact

HEALTH HISTORY

NAME: **DATE:**

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

AIDS/HIV	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Periodontal/Gum Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Influenza	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Migraine Headache	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Detached Retina	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Pace Maker	☐ Yes	☐ No	Other _____		
Fractures	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No	Other _____		
Glaucoma	☐ Yes	☐ No						
Goiter	☐ Yes	☐ No						

PRIMARY DOCTOR (MD)	
Doctors Name	Phone

HOSPITALIZATIONS/SURGERIES			**PREGNANCIES** (Females only)	
Year	Hospital	Reason for Hospitalization and outcome	Year	Complications, if any

MEDICATIONS you are currently taking.	**ALLERGIES** To medications or substances

FAMILY HISTORY. (List the major health problems each of these relatives have or had.)	
Mother:	
Father:	
Brothers:	
Sisters:	

PERSONAL INJURY QUESTIONAIRE

NAME _____ DATE: _____.

Accident date: _____ Type of accident: □ Automobile □ Slip and Fall □ Work Related

Were you: □ Driver □ Front Passenger □ Right Rear Pass. □ Middle Rear Pass. □ Left Rear Pass.

Were you wearing a seatbelt? □ Yes □ No Did your airbag deploy? □ Yes □ No

Were you impacted on the: □ Front □ Behind □ Drivers side □ Passenger side

Speed of your car: □ Stopped □ moving at approx._____ mph Other cars speed ___mph

Were you knocked unconscious? □ Yes □ No If yes, how long?_____

Did you get out of the car yourself? □ Yes □ No I was helped/taken out by _____.

After the accident I: (check all that applies)
□ was taken by ambulance to _____hospital □ was examined □ had x-rays taken
□ given a prescription □told to follow-up with my doctor □ Went home and rested □ Went to work

□ Other _____
_____

How did you feel after the accident:
Just after: □Shock □Neck pain □Mid back pain □Low back pain □Arm pain □Leg pain □Headache
Later that day: □Neck pain □Mid back pain □Low back pain □Arm pain □Leg pain □Headache
The next day: □Neck pain □Mid back pain □Low back pain □Arm pain □Leg pain □Headache

Have you missed work due to this accident?

□ YES, unable to work in any capacity from _____ to _____.

□ YES, able to work part-time with restrictions after this accident.

□ NO, able to work full-time with restrictions after this accident.

□ NO, able to work full-time without restrictions after this accident.

_____DO NOT WRITE BELOW THIS LINE_____.

Previous accident or similar injury ?

□ NO □ YES Describe:_____.

□ Treated for this and suffered some residual impairment and disability from it.

□ Treated for this and released with no permanent impairment.

□ Not treated for this injury.

□ No problems immediately prior to this accident.

Description of this accident:_____
_____
_____
_____
_____
_____

Patient Financial Policy

TO ALL PATIENTS: Please read the following and initial, indicating that you understand them.

_____I have obtained an attorney or will obtain an attorney within 48 hours.
_____I understand that I am responsible for my bill even if I do not receive a settlement.
_____I understand that I am responsible for my bill if my attorney drops my case.
_____I understand that I am responsible for my bill if I drop my attorney.
_____I agree to provide any and all information on my case to the office as it is received.
_____I agree to provide any changes in information to the office. (Address, phone number, etc.)

TO ALL PATIENTS: Please understand that we do bill your insurance.

*** If you have Med Pay under your insurance policy we obtain the right to bill them for our services.**

- If the accident was not your fault, your auto insurance cannot raise and/or cancel your insurance.
- Med Pay is an optional coverage. If you have it, your paying for it, use it.
- By using your Med Pay a portion of your bill here with our office will be paid.
- Why is that a good thing? When you get your settlement most likely your bill with us would have been paid whatever limit your policy allows. (In some cases it is completely paid in full.)

*** If you have health insurance we obtain the right to bill them also.**

- We bill your health insurance for the same reasons we bill your Med Pay.
- If you are working with an attorney you are not responsible for paying your deductible or co-pays to us up front. We hold your bill until your case settles.
- You are only immediately responsible for these things if your case is dismissed or you are no longer being represented by your attorney.
- Your insurance should pay the percentage allowed according to your policy. (70 to 80 percent in most cases.)
- Again, if you have it, your paying for it, use it.

***Payment Options**

- **We will hold the remainder of your bill until your case settles.**
- If you are responsible for making payments towards your bill at the end of your treatment we have the options of accepting.
    - Cash, Check, and credit cards.

***Patient's or Authorized Person's Signature**

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. I also request payment of government benefits either to myself or the party who accepts assignment below.

SIGNED_____ DATE_____

PRINT NAME_____

RELEASE OF AUTHORIZATION, DIRECTION TO PAY
AND
FINANCIAL RESPONSIBILITY AGREEMENT

I, _____, hereby authorize this office to furnish my attorney, _____, and/or _____ Insurance Company, or the designee of either, any medical information requested concerning the condition or treatment of injuries sustained by me or my children, on _____.

I authorize and direct the third party liability carrier and/or my attorney, to furnish, directly to this office, a separate check, for the full balance, for all professional services rendered. I further authorize any third party liability carrier and/or my attorney, to disclose the settlement status, settlement statement and/or a copy of the settlement check if requested.

I understand that this in no way relieves me of my personal primary responsibility to pay my doctor for professional services (including any expert witness fee) when a statement is rendered and that I will receive customary billing for said services. I agree that this office is given a Power of Attorney to either endorse or sign any and all checks presented to them for payment of my medical bill with or without direct notification to me.

I understand that I am being treated for injuries sustained in an accident. Because of the laws governing treatment in cases such as mine, the treatment plan, which has been recommended in my case, must be strictly adhered to. I understand that **failure to keep my appointments, without a reasonable excuse, may lead to dismissal** from treatment and may jeopardize future treatment and/or benefits such as the insurance carriers responsibility for medical costs and/or compensation for pain and suffering. **Dismissal or if I discontinue care my full balance will be due immediately**.

I further understand that I will be treated until I have reached a maximum of improvement at which time I will be released from treatment resulting from the injuries sustained in the accident. This is not meant to imply that I will not need further treatment but only that the injuries sustained in the accident have reached maximum improvement.

Once released from care, I will keep in contact with the office manager as to the status of my case.

□ I am **not being represented** by an attorney: I agree that, **upon settlement, full balance is due immediately**. If **after sixty** (60) days of reaching maximum improvement, no settlement has been made, I will begin making **$100.00 per month** payments. I further acknowledge that if **after 180 days**, from my release date, no settlement has been reached my **full balance may be due immediately**.

□If I **cease being represented** by an attorney, for any reason, or if you are **unable to contact** my attorney: my **full balance may be due immediately**

I hereby acknowledge that should the net recovery not be sufficient to pay in full all amounts due this office with respect to the above stated matter, then I shall remain personally responsible for any unpaid balance.

_____ _____
Patient Signature Date Witness Signature Date

_____ _____
Patient Name Witness Name