

Confidential Patient Data

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

PATIENT INFORMATION

Today's Date: _____

Name: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which Number do you prefer we make reminder calls to: Home Work Cell

Social Security #: _____ Date of Birth: _____ Age: _____

Email Address: _____

Marital Status: Married Single Divorced Separated Other _____

Your Occupation _____ Your Employer: _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Mail Newspaper Doctor _____ Other _____

MEDICAL/FAMILY HISTORY 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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venerea disease

Do you have a family physician? Yes No Physician's Name: _____

Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No

ACCIDENT HISTORY Job Auto Other 1. _____ Date: _____
 Job Auto Other 2. _____ Date: _____
 Job Auto Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms(1-10, with 1 being least serious)

- 1. _____
- 2. _____
- 3. _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches^^^^ Numbness °°°° Pins/Needles ●●●● Stabbing ////

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT
 OTHER ACCIDENT ILLNESS UNKNOWN CAUSE GRADUAL ON
DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S)
_____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? _____

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND AND FOR WHAT CONDITION?

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

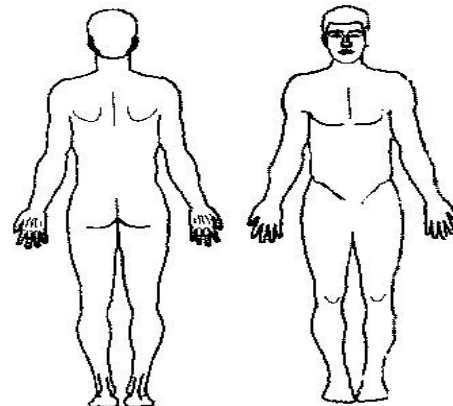
- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
- LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion
- constipation depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever
- stomach upset head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell
- loss of taste low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms
- pins and needles in legs ringing in ears shortness of breath stiff neck



Patient's Signature: _____ Date: _____

Satilla Spine Center

Authorization Form

RESPONSIBILITY OF BILL

Patients are responsible for the full payment of services rendered. We accept cash, personal checks, Visa, Master Card, and American Express. All professional services are charged to the patient receiving care and/or the insurance provider. Any charges exceeding the benefit coverage are the responsibility of the patient. We will not become involved in disputes with your insurance company or attorney regarding deductibles, co-payments, co-insurance, covered charges, secondary insurance, "medical necessity", etc. other than to supply factual information and claim submission.

INITIALS _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage with _____ insurance company and assign directly to Satilla Spine Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Satilla Spine Center may use my healthcare information and may disclose such information to the above-names insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PATIENT SIGNATURE _____

RELEASE OF INFORMATION

I hereby authorize _____ to release my records to Satilla Spine Center.

INITIALS _____

AUTHORIZATION FOR RADIOGRAPHIC ANALYSIS

Consent is hereby given the undersigned for radiographic analysis necessary for chiropractic interpretation.

INITIALS _____

NOTE TO FEMALES: YOU MUST NOTIFY THE DOCTOR OF PREGNANCY OR POSSIBILITY OF PREGNANCY BEFORE RADIOGRAPHS ARE TAKEN.

CONSENT FOR TREATMENT OF A MINOR

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctor and performed by the technical staff of SATILLA SPINE CENTER. The undersigned states that he/she is the patient's legal guardian.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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) and understand the Notice.

SIGNATURE: _____ DATE: _____

(Turn Page Over)

Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you do not have insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$150 at any time or care may be terminated. Our financial plans make care an affordable part of your family budget.
2. **If you have insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$150 or care may be terminated. Our financial plans make care an affordable part of your family budget.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you are responsible for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Patient Signature: _____

Date: _____

No Show Policy

Our goal at Satilla Spine Center is to provide the best care we can to our patients! We understand that your time is as valuable as ours; this is why we have a "No-wait" policy. We strive to serve our patients as closely to their scheduled time as possible to prevent delays in your day.

We ask that if you are unable to make your scheduled appointment please call our office at least one hour prior to your scheduled time to change the time of your appointment or reschedule to another day. If you are running late due to means beyond your control please call the office at 912.287.1414 so we are aware of the delay.

Effective April 1, 2007, if notification is not made one hour prior to the scheduled time there will be a \$35.00 No Show Fee for adults and \$15.00 No Show Fee for Children.

Thank you,
Satilla Spine Center

Patient Signature: _____

Date: _____