Please answer the following questions completely.

Name _____ SS# _____
Address _____ Apt # ____ City _____ State ___ Zip _____
Home Phone ( ) _____ Work Phone ( ) _____
Best Place to Reach You: ☐ Home ☐ Work ☐ Cell Phone ( ) _____
E-mail Address: _____
Employer: _____ Occupation _____
Sex: M F Marital Status: S M D W Age: _____ Date of Birth ____/____/____

Describe Chief Complaint: _____

Have you had Chiropractic Care before? _____ Yes _____ No
Is it possible you are Pregnant? _____ Yes _____ No

Do you have health insurance? _____ Yes _____ No
Are you on Medicare? _____ Yes _____ No

Are you here because of: _____ An auto accident? _____ An on the job injury?
Date Injured: _____
Do you have an attorney? _____ Yes _____ No

Date of last physical exam: _____ Reason: _____

Please list all accidents, falls, injuries, surgeries, and major illnesses.

TYPE	DATE	DESCRIBE/COMMENTS

Are you presently taking any medications?

NAME OF DRUG	AMOUNT	DESCRIBE/COMMENTS

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

__Headaches
__Shooting head pains
__Sinus pain
__Loss of smell
__Hay fever
__Loss of taste
__Tightness in throat
__Inflammation in throat
__Thyroid trouble
__Face flushed
__Twitching of face
__Loss of memory
__Fatigue
__Depression

__Head feels too heavy
__Dizziness
__Fainting
__Loss of balance
__Ringing in ears
__Muscle spasms in neck
__Grating in neck
__Tight shoulder muscles
__Neuritis-arms/shoulders
__Pins & needles
__Arms/hand pain
__Cold hands
__Chest pains
__Shortness of breath

__Heart pain
__Heart palpation
__Mid-back pain
__Heart attacks
__High blood pressure
__Anemia
__ Nervous stomach
__Stomach trouble
__Ulcers
__Nerves & nervousness
__Irritability
__Cold sweats
__Liver trouble
__Gallbladder trouble

__Indigestion
__Intestinal gas
__Low back pain
__Constipation
__Menstrual cramps
__Menstrual irregularity
__Diabetes
__Swelling
__Arthritis
__Slipped disc
__Pinched nerve
__Irregular sleep
__Leg/feet pain
__Neck pain

Are any of your family members experiencing any of the above difficulties?

Family Members: _____ Difficulties _____
_____ _____
_____ _____

Please complete all applicable information

How did you hear about our office: _____

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED. AS A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU.

- ☐ **Cash/Check/Credit Card:** Payment is due in full when services are rendered. We accept Visa, Master Card, American Express, and Discover cards for payment.
- ☐ **Insurance:** We will file your medical insurance for you. We must have a copy of your health insurance card as well as your driver's license for your file. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Automobile Insurance:** We must have verification of insurance, a copy of your insurance card, a copy of your driver's license, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Workers Compensation:** Authorization for treatment must be in writing from your employer. If this is not possible on the first visit, we will accept verbal authorization until authorization can be obtained in writing.
- ☐ **Medicare:** We must have a copy of your Medicare card for verification of coverage.

Insurance Information:

Insured Full Name: _____ Insured Date of Birth ____/____/____
Relationship to the Insured: _____ Insured Home Phone ( ) _____
Insured SS#: _____
Insurance Company Name: _____
Insurance Company Phone: ( ) _____ Group #: _____
Insured Employer: _____ Employer Phone: ( ) _____

*I authorize the release of any information pertinent to my case to any insurance company or adjuster for purposes of obtaining payment for my bills. **Signed:** _____

*I further authorize and direct the _____ Insurance Company to pay North Atlanta Chiropractic Center directly for services rendered to me.
Signed: _____ Date _____

*Due to new government regulations, please give North Atlanta Chiropractic Center permission to display your name in our office for our patient showcase's such as sign in sheets and our display boards, etc.
I give permission for North Atlanta Chiropractic Center to display my name for in office use only.
Signed: _____ Date _____

*I _____, have read the above and checked of one method of payment. I have agreed that the unpaid balance is my responsibility and will pay any balance that has gone unpaid over 60 days.

Patient Signature: _____

Witness: _____
Date: _____