PATTERSON CHIROPRACTIC CENTER

NEW PATIENT
CONFIDENTIAL HEALTH RECORD

Name (Last)_____ (First)_____ (Middle)_____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital S M D W Sex M F SS #_____ Spouse's Name _____

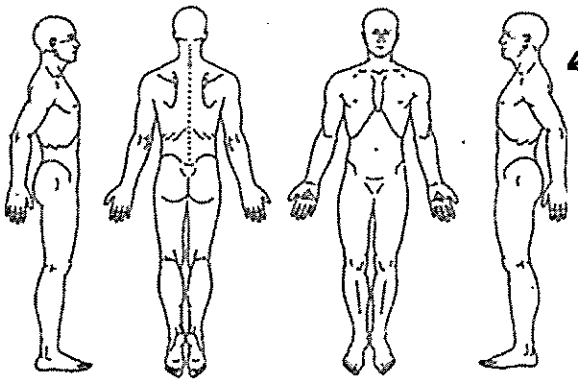
Home # (___) _____ Work # (___) _____ Cell # (___) _____ E Mail _____

Patient's Employer _____ Job _____

Work # (_____)_____

Referred by _____

Insurance Co. _____ Group# _____ ID # _____



Please outline and shade where you have pain or other symptoms

* **When did your symptoms start?** _____
* **How did your symptoms begin?** _____

_____

Did symptoms begin ____ suddenly or ____ gradually?

1. PRIMARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

Since it started is your condition:
___ Better ___ Worse ___ Same

2. SECONDARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

Since it started is your condition:
___Better ___ Worse ___ Same

3. ADDITIONAL conditions:

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

Since it started is your condition:
___Better __Worse ___ Same

Have you seen another doctor for your CURRENT condition(s)? ___ No ___ Yes Who_____

When _____

Have you had previous tests or studies for your CURRENT condition(s)? ___ No ___ Yes When_____

Have you had previous medications or care for your CURRENT condition(s)? ___ No ___ Yes When_____

Have you lost time from work due to this CURRENT problem? ___ No ___ Yes When_____

Have you had SIMILAR symptoms in the past? ___ No ___ Yes When_____

Have you had Chiropractic care before? ___ No ___ Yes When_____

To your knowledge, are you pregnant? ___ No ___ Yes

Your Past History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Grandparents' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Parents' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Siblings' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems

Current Medications:

Rx Name & Dosage Strength	Rx Name & Dosage Strength	Rx Name & Dosage Strength
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Social History: __ Never Smoked __ Former Smoker __ Current Smoker
__ No Alcohol __ Drink Alcohol __ No Recreational Drugs

Allergies: __ Sinus / Respiratory __ Food / Digestion __ Skin
__ Prescription Medicine (Names Allergic To)_____

Surgeries/Hospitalized:
Type/area_____ Surgeon_____ When?_____
Type/area_____ Surgeon_____ When?_____
Type/area_____ Surgeon_____ When?_____
Type/area_____ Surgeon_____ When?_____

Current Vitals: **Height** _____**ft.** _____ **inches** **Weight** _____**lbs.**

Patient Signature **Date**

In general, my health is:	__ Excellent	__ Very Good	__ Good	__ Fair	__ Poor
Compared to a year ago, my health is:	__ Excellent	__ Very Good	__ Good	__ Fair	__ Poor
Decrease of social activities during the past 4 weeks:	__ Not at all	__ Slightly	__ Moderately	__ Quite a bit	__ Extremely

General:	__ Fatigue	__ Weakness	__ Fever __ Chills	__ Night Sweats	__ Weight Gain or __ Weight Loss
Skin:	__ Pain	__ Rash	__ Redness	__ Itching	__ Eczema
Eyes:	__ Pain	__ Discharge	__ Infection	__ Vision Trouble	
Ears:	__ Pain	__ Discharge	__ Infection	__ Loss of Hearing	__ Ringing
Nose:	__ Pain	__ Bleeding	__ Infection	__ Absence of smell	__ Obstruction
Mouth/Throat:	__ Pain	__ Bleeding	__ Gum Disease	__ Abnormal Taste	__ Lesions
Heart:	__ Pain	__ Palpitations	__ Edema/ Swelling	__ Murmur	__ Fainting
Lungs:	__ Pain	__ Cough	__ Phlegm	__ Difficult breathing	__ Bloody Discharge
Gastrointestinal:	__ Pain	__ Nausea	__ Diarrhea	__ Constipation	__ Weight Change
Genitourinary:	__ Pain	__ Discharge	__ Blood in Urine	__ Incontinence	__ Frequent Urination
	__ Sterility	__ Impotence	__ Abnormal Bleeding	__ Amenorrhea	
Endocrine	__ Hair Loss	__ Thirsty	__ Tremors	__ Hot/cold intolerance	__ Sleep issues
Neurological:	__ Headaches	__ Seizures	__ Dizziness	__ Numbness	

Any additional information that you feel is relevant to your appointment today? _____

_____

APPLICATION FOR TREATMENT

Please check the type of care desired: ☐ Temporary Relief ☐ Lasting Correction

Are you interested in improving your overall health? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me and charged to me are my responsibility to be paid to the doctor. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ **DATE** _____

PATIENT'S NAME PRINTED _____ **DATE** _____

GUARDIAN'S SIGNATURE _____ **DATE** _____

How We Protect Your Private Health Information

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Patterson Chiropractic** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above states purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at the practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

I understand I have a right to review this office's Notice of Privacy practices prior to signing this document. This office's Notice of Privacy has been provided to me. This Notice of Privacy Practices describes the type of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of this office. The Notice of Privacy Practices for this office is also provided upon request at the main administrative desk of this office. Notice of Privacy Practices also describes my rights and this office's duties with respect to my protected health information.

This office has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at **478-987-7555** and requesting a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that this office or **Dr. Craig Patterson** have taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient Printed Name	Patient Signature	Date
Witness Printed Name	Witness Signature	Date

Patterson Chiropractic Center, Inc
1304 Macon Rd.
Perry, GA
31069
478-987-7555

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN
ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Patterson Chiropractic Center; J. Craig Patterson,D.C.; Spencer Patterson,D.C.; Kyle A.Yawn.D.C., as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been or will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result to services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare the Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20_____.

X_____(SEAL)
(patient signature)

X_____
(please print patient name)

X_____(SEAL)
(signature of Guardian if applicable)

Revised August 27, 2015