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 __________________

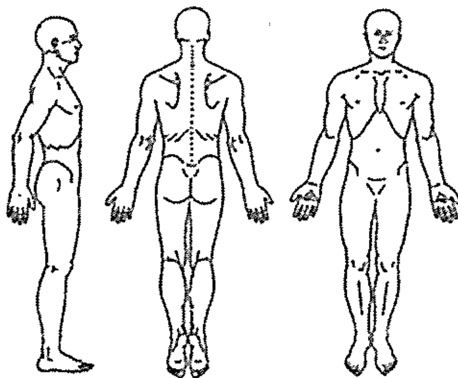
Home # (___) _______________ Work # (___) ______________ Cell # (___) _______________ E Mail ____________________________

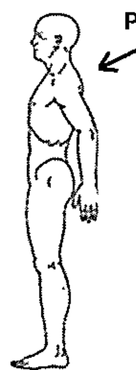
Patient's Employer ____ Job ______________________________

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%)
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___ 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):**
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___ Sharp ___ Shooting
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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

COLLISION INFORMATION

Patterson Chiropractic Center 1304 Macon Rd. Perry, GA 31069

Name: ______________________________ Today's Date: __________

Where did the collision occur: Street: ______________________ City: ______________ State: ______

Date when collision occurred: ________________ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right

Describe what happened: ______________________________

____

____

____

____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?

❑ Yes ❑ No If passenger, did your hands brace yourself?

❑ Yes ❑ No Did you have your seat belt and shoulder strap on?

❑ Yes ❑ No Was your seat up at the time of impact?

❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?

❑ Yes ❑ No Did the seat belt engage?

❑ Yes ❑ No Did the airbag engage?

❑ Yes ❑ No Did you hit the dash, steering wheel or window?

❑ Yes ❑ No Did you know you were going to be hit?

❑ Yes ❑ No Did you brace yourself with hands or feet?

❑ Yes ❑ No If driving, was your foot on the brake at impact?

❑ Yes ❑ No Was your head turned at impact?

❑ Yes ❑ No Were you leaning forward?

❑ Yes ❑ No Did your glasses fly-off at impact?

❑ Yes ❑ No Was your body turned at the moment of impact?

❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?

❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?

What part of the vehicle was hit? ______________________________

1. What make and model of vehicle were you in? ________________ The other vehicle? ________________
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? ______________________________
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know? ______________________________

____

Patterson Chiropractic Center

1304 Macon Rd. Perry, Georgia 31069
478-987-7555 phone 478-988-4508 fax

Patient Financial Agreement/Lien
(Equitable Lien/Assignment Contract and Indemnification Agreement)

Patient Name____

Please read the following very carefully as it concerns your financial responsibility to the Health Care Provider from whom you are about to receive services.

I, the undersigned patient, hereby agree to establish a lien and assignment of benefits or claim in favor of **Patterson Chiropractic Center** by this contract and pursuant to any state statues that apply in the state where I reside. I give my permission for **Patterson Chiropractic Center** and/or their agent to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred on ________________________, and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so I have entered into a contract with the above named health care or service provider. This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy, settlement, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident in such sums necessary to fully compensate the health care or service provider from whom I received care. This lien and assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority over any subsequent liens or assignments of my interests.

In exchange for providing necessary medical care without requiring payment at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement. Included are any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and/or servicing notice of this lien/assignment upon any liable parties and their insurance companies. Also included are any collection charges or legal costs and fee incurred by the provider while attempting to collect the medical bills related to this claim is such activity becomes necessary.

I further understand that as part of the process of recording a lien/assignment, I will received a copy of the lien/assignment, and that this copy is for my own records and does not require any response on my part.

______________________________	__________________________
Patient or Guardian Signature	Date
______________________________	__________________________
Witness	Date