

Patient Information

Name _____

First Middle Last

Birth date _____ Age _____

Address _____

Home Phone _____ Cell Phone _____

City _____ State _____ Zip _____

Email Address _____

Insurance Company _____

Social Security # _____

Sex [M F] Spouse's Name _____

Employer's Name _____

Spouse's Date of Birth _____

Occupation _____

Marital status – [M W D S]

Children's Names _____

Have you had chiropractic care before? _____ When? _____

What is your current complaint? _____

Is the current condition due to: [] Auto accident [] Work injury [] Other accident [] Illness [] Unknown cause

Date symptoms appeared? _____ Please describe what happened: _____

What makes your condition worse: [] Standing [] Twisting [] Bending [] Sitting [] Lying [] Walking [] Coughing [] Lifting

This issue is affecting my [] Job [] Playing with kids [] Marriage/Relationship [] Golf/Tennis [] Sleep [] Digestion [] Attitude

When the problem is at its worst, how does it make you feel? _____

Are your symptoms:

- Improving (101)
- About the same (102)
- Getting Worse (103)
- Intermittent (come and go) (104)

List all surgical operations:

(107)

List all vitamins and supplements

you now take: (109)

Have you had these symptoms before?

- NO (105)
- YES When? _____

List all prescription and

non-prescription drugs

you now take: (108)

Check here if you have a family

history of:

- arthritis (110)
- cardiovascular disease (111)
- diabetes (112)
- cancer (113)

Who is your family doctor? (106)

Dr. _____

Can I contact you doctor Y/N

Social Habits: (114) [] tobacco

[] alcohol

[] coffee

Exercise Activity: (115) [] no exercise program

[] light exercise

[] moderate exercise

[] strenuous exercise

Stress levels: (116) [] little or no

[] minimal

[] moderate

[] greatly-stressed

Physical Activity: (117) [] sitting 50% or more [] light labor [] manual labor [] heavy labor [] repeated motion

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU MAY HAVE HAD: (118)

High Blood Pressure

Asthma

Gastric Ulcers

Joint Pains

Heart Disease

Bronchitis

Colitis/Spastic Colon

Jaw Pain

Heart Murmurs

Pulmonary Disease

Acid Reflux

Shoulder Pain

Diabetes

Emphysema

Hiatal Hernia

Numbness

Headaches

Pneumonia

Gas/Bloating

Hepatitis A B C

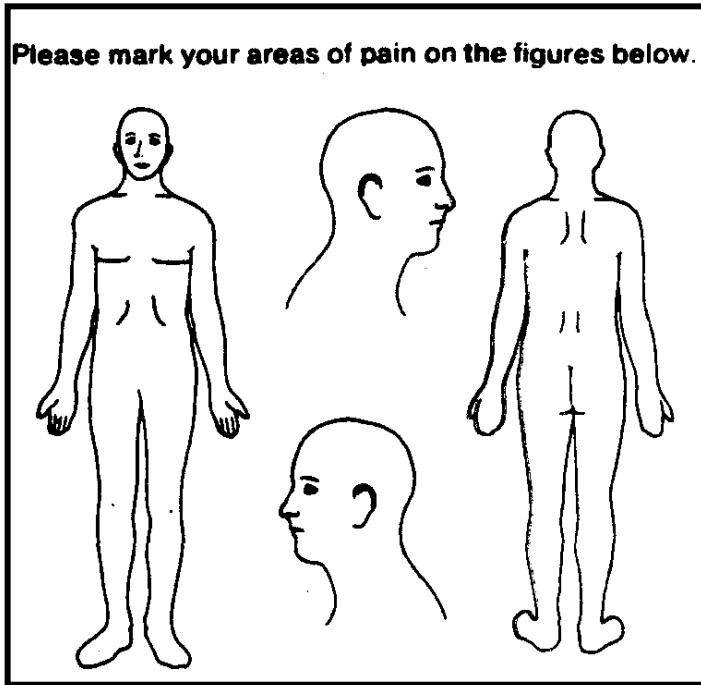
Sinus/Allergies

Kidney Stones

Premenstrual Pains

HIV+ / AIDS

How did you hear about our office? [] Friend, Whom? _____ [] Other? _____



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Moss Family Chiropractic** may prepare any necessary reports to assist me in making collection from my insurance company and that any amount authorized to be paid directly to **Moss Family Chiropractic** will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspended or terminate my care and treatment, any fee for services will be immediately due and payable.

On a scale of 1 – 10 please circle your level of commitment to correcting the cause of your symptoms.

Temporary												Maximum
Relief	1	2	3	4	5	6	7	8	9	10		Correction

This patient information is true and accurate to the best of my knowledge.

Signature _____ Date _____

About Our Fees

Moss Family Chiropractic

8016 Cumming Hwy. Suite 304 Canton, GA 30115

We realize that there is no amount of money that accurately reflects the cost of an adjustment when it restores lost health. Therefore, we ask you read the following and let us know which way you expect to handle your account.

Please indicate which of the following best suits your situation:

- General Insurance: Your insurance will pay a certain percentage of your benefits. You are responsible for the deductible and any remaining portion that your insurance does not cover.
- Personal Injury: You have been in a car accident and will either be: a) filing through your car insurance, b) contacting a lawyer, or c) receiving a settlement.
- Non-insured
- Medicare: We will be glad to submit your claims to Medicare for you, but we do not accept assignment. This means that you are responsible to pay for your services when rendered, and Medicare will reimburse you by mail.

I understand that any X-Rays taken in this office are part of my permanent record and must remain in this office. If you ever need to take these X-Rays to another doctor, you may borrow these films for up to 30 days with a refundable deposit. However, these X-Rays must be returned to this office.

Remember, our primary goal is to help you become healthy. If health is priority, we will work with you in any way to help you reach that goal.

Signature _____

Moss Family Chiropractic

Consent for Treatment & Assignment

I authorize Moss Family Chiropractic and whomever they may designate as their assistant to provide treatment as deemed necessary. I understand, as with any treatment, no specific result of benefit is guaranteed. I assign payment directly to Moss Family Chiropractic for services provided and I am responsible for any deductibles, co-payments, or unpaid balances to Moss Family Chiropractic.

Patient Signature

Date

Personal Representative

Date

Authorization To Release Medical Information

I authorize the release of any medical information to expedite the processing of my insurance claim(s), to process my personal injury claims, or to share my medical information with another physician in which the patient has been referred.

Patient Signature

Date

Personal Representative

Date

Health Care Authorization

I give permission to Moss Family Chiropractic to contact me with appointment reminders, missed appointment notification, birthday/holiday cards, newsletters, and allow my name to be posted on the New Patient/Referral Board. I also give permission to disclose protected health information in the presence of anyone accompanying me into a treatment room, or consultation room by my request. By signing this form you are giving Moss Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above. You have the right to refuse to sign this authorization. If you refuse to sign this, Moss Family Chiropractic will not refuse to provide you treatment.

Patient Signature

Date

Personal Representative

Date

HIPAA Notice

I have read and understand the Notice of Privacy Practices for Protected Health Information.

Patient Signature

Date

Personal Representative

Date

EXPIRATION: This Authorization shall expire on the following date: April 1, 2020