CUMMING CHIROPRACTIC CENTER

Discover what Chiropractic Wellness can do for you

PATIENT INTRODUCTION CARD

Child 14 and under

Date _____

SSN

First Name

Middle Name

Last Name

Address

City

State/Province

Zip Code

Home Phone

Cell Phone

Work Phone

How would you prefer to receive appointment reminders?

Email

Phone carrier

Would you like your appointment reminder 4 hours or 1 day before appointment?

Age

Birthday

Number of siblings with ages

Mother's name

Mother's Cell

Father's name

Father's cell

Name of school

Sports/ Activities

Do you have insurance? If so, what company?

Who is the primary insured?

Insured's date of birth

Describe the birth process?

- ☐ Had difficulties
- ☐ No difficulties
- ☐ Full term
- ☐ Premature
- ☐ Natural
- ☐ Epidural
- ☐ C-Section
- ☐ Forceps
- ☐ Extraction (suction cups)
- ☐ Other

If there were other complications, please describe

Describe health concerns in detail, how it happened and your pain level (1-10, 10 being severe)

Date symptoms occurred?

Ever had similar symptoms?

Is condition related to auto accident?

Describe the care received before coming to this office and results

What you ever had chiropractic care before? If so, where and when?

Do you wish for spinal correction or temporary relief of your condition?

Have you ever had surgery before? If yes, give reason, month, and year

Are you taking medication? If yes, please give type, dosage and what it is for

Have you ever had any fails, accidents or injuries? If yes, please explain (give month & year)

Describe injured area(s)

I authorize Dr. Joseph Gregory, D.C, and whomever he may designate as his assistant to administer chiropractic care as he deems necessary to my child

Child's Name

Signature

Date Signed

Printed Name

Email

Review of Systems

Please select one of the three options for each of the categories below (1- Presently Have, 2- Previously Had, 3- Due to Current Injury)

General

Cancer

Stroke

Broken Bones

Cortisone Use

High Blood Pressure

Seizures / Epilepsy

Diabetes

Headache

Dizziness / Fainting

Unexplained Weight Loss

Drug or Food Allergy

Excessive Thirst

Constant Fatigue

Night Sweats

Eyes, Ears, Nose, and Throat

Asthma

Colds

Sore Throat

Deafness	**Dental Decay**	**Earache / Frequent Ringing in Ears**
Ear Discharge	**Sinus Infection**	**Enlarged Glands**
Enlarged Thyroid	**Nose Bleeds**	**Worsening Vision**
Far-Sightedness	**Gum Trouble**	**Hay Fever**
Hoarseness	**Nasal Obstruction**	**Near-Sightedness**

Musculoskeletal

Arthritis	**Bursitis**	**Tendonitis**
Hernia	**Low Back Pain, Stiffness, or Soreness**	**Mid-Back Pain, Stiffness, or Soreness**
Neck Pain, Stiffness, or Soreness	**Shoulder Pain or Numbness**	**Arm Pain or Numbness**
Elbow Pain or Numbness	**Hand Pain or Numbness**	**Hip Pain or Numbness**
Foot Pain or Numbness	**Knee Pain or Numbness**	**Leg Pain or Numbness**
Painful Tailbone	**Poor Posture**	**Sciatica**
Scoliosis		

Genito-Urinary

Urgent Sensations to Urinate	**Blood in Urine**	**Frequent Urination**
Inability to Control Bladder	**Kidney Infection / Stones**	**Painful Urination**
Prostate Trouble	**Pus in Urine**	**Painful Menstruation**
Hot Flashes	**Irregular Menses**	**Lumps in Breasts**

Cardiovascular

Hardening of Arteries | **Low Blood Pressure** | **Dizziness**

Pain over Heart | **Poor Circulation** | **Rapid Heartbeat**

Slow Heartbeat | **Swelling in Ankles**

Respiratory

Chest Pain | **Chronic Cough** | **Difficulty Breathing**

Spitting Up Blood | **Spitting Up Phlegm** | **Wheezing**

Gastrointestinal

Belching / Gas | **Colitis** | **Colon Trouble**

Constipation | **Diarrhea** | **Difficult Digestion**

Distention of Abdomen | **Excessive Hunger** | **Gallbladder Trouble**

Hemorrhoids | **Intestinal Worms** | **Jaundice**

Liver Trouble | **Nausea** | **Pain over Stomach**

Poor Appetite | **Vomiting Blood** | **Vomiting**

Other

Employment, Activities of Daily Living (ADL's) and Recreation Information

Description of job

Condition's Effect On Job Performance:

Daily Activities: Effects of Current Condition on Performance

Bending

Caring for family

Carrying groceries

Changing position from sit to stand

Climb stairs

Driving

Extended computer use

Feeding

Household chores

Kneeling

Lift children

Lifting

Pet care

Reading / Concentration

Self care- bathing

Self care- dressing

Self care- shaving

Sleep

Static sitting

Static standing

Walking

Yard work

Please list 3 recreational activities and any effects of the current condition on your ability to perform. For example "gardening- moderate pain (limited)"

Authorizations and Release

Financial Agreement

Before the Doctor(s) of Cumming Chiropractic Center can provide you with their services, it is important that all financial arrangements be clearly understood. Our agreement for your health care is with you alone. Your insurance is not a part of this agreement. Policy benefits vary from company to company and from policy to policy within each company, you are advised that you may or may not be fully compensated under the provisions of your own insurance policy. Please note that the carrying of insurance by us is done as a courtesy to our patients. While insurance claims are being processed, your coinsurance/payment is due at the time of service.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that | am personally responsible for payment.

Signature

Date Signed

Printed Name

Email

Medical Information Authorization to Release

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Signature

Date Signed

Printed Name

Email

Request for Payment of Benefits to Provider of Care

I hereby authorize the Insurance Company/Insurance Administrator listed to pay by check, and for it to be mailed directly to Cumming Chiropractic Center the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. | have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Please list insurance company here

Signature

Date Signed

Printed Name

Email

Acknowledgement of Receipt of 'Notice of-Patient' Privacy Practices

I have read or been provided with a Notice of Patient Privacy Practices that provides a description of healthcare information uses and disclosures, I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Signature

Date Signed

Printed Name

Email

Consent for Treatment of Minor (under age 18)

I hereby authorize the Doctors of Cumming Chiropractic Center and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to the minor listed.

Please list the minor's name

Please list your relationship to the minor

Signature

Date Signed

Printed Name

Email

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures: I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk ismost often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition,and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per onemillion to one per two million, have been associated with chiropractic adjustments.Treatment objectives as well as the risks associated with chiropractic adjustments and, all other proceduresprovided at Cumming Chiropractic Center have been explained to me to my satisfaction and I have conveyed myunderstanding of both to the doctor. After careful consideration, I do hereby consent to treatment by anymeans, method, and or techniques, the doctor deems necessary to treat my condition at any time throughoutthe entire clinical course of my care.

Signature

Date Signed

Printed Name

Email

REGARDING: X-rays/Imaging Studies

FEMALES ONLY > please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

Please select your sex

Please check all that apply

- [ ] The first day of my last menstrual cycle was on the date provided
- [ ] I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

First day of last menstrual cycle

Signature

Date Signed

Printed Name

Email

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and | have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Medical Records Authorizations (HIPAA)

I authorize to release my medical records to the person(s) or organization listed below: I hereby request and authorize you, your employees and agents of Cumming Chiropractic Center to furnish to theperson(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies ofx-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relatingto any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or mayhave in the future.

Name of person(s) medical record may be released to (if applicable). If not, write "Information is not to be released to anyone. "

This Release of Information will remain in effect until terminated by me in writing.

Please call my

- [ ] Home
- [ ] Work
- [ ] Cell

Phone number

If unable to reach me:

Describe other

Signature

Date Signed

Printed Name

Email

Photo Release

I give Cumming Chiropractic Center permission to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

OR

I decline the right to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Please select

Signature **Date Signed**

Printed Name **Email**

24 Hour Cancellation and "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Cumming Chiropractic Center reserves the right to charge a fee of $25 for all missed appointments, "no shows", and appointments without a compelling reason, are not cancelled with a 24 hour notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature **Date Signed**

Printed Name **Email**

Describe injured area(s)