CONYERS FAMILY CHIROPRACTIC CENTER
2365 Wall St, Suite 100, Conyers, GA 30013 (770)922-8187

OFFICE USE ONLY: Chart#_____
ACT. TYPE_____ PROVIDER: _____

Date: _____ How did you hear about our office? _____
Title: ____ First Name: _____ MI: _____ Last Name: _____ Preferred Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
SSN# _____ Date of Birth: _____ Sex: M F Marital Status: S M W D Age_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Fax: _____ Email: _____Occupation_____
Emergency Contact: _____ Phone Number _____
Are you here do to an accident? Yes No If yes, provide the cause of injury: _____ Date of injury: _____
I certify that the above information is true and correct. **Signature:** _____ **Date:** _____

Authorization, Assignment of Benefits, and Release of Records: I authorize the doctor to discuss my treatment and release my records with or to the following people: Spouse_____ Doctor_____
Children_____ Parents_____ Other_____

Patients with insurance or third party pay please understand that we may have to send copies of your medical records to your insurance company if requested, or for insurance to determine payment of claim. See "Notice of Patient Rights and Privacy Protections under Federal Privacy Laws (HIPPA)"

Please initial where it applies: I authorize CFCC to text appointment reminders to me:_____

I authorize CFCC to leave voice messages on my home_____ or cell phone_____

I authorize CFCC to send me reminders, birthday cards, newsletters, and special event notifications, including post cards by Email_____ and Mailing Address_____

I authorize payment of my insurance benefits directly to the chiropractor and/or chiropractic office. **I understand and agree** that health and accident insurance policies are an arrangement between an Insurance Carrier and myself.
Signature: _____ **Date:** _____

I understand that CFCC will prepare any necessary reports and forms to assist me in collecting from the insurance company. Any amount paid to CFCC will be credited to my account. **INT.** _____

I authorize CFCC to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for payment of charges incurred by me as a result of professional services rendered and hereby release them of any consequence thereof. **I agree** that a scanned copy of this agreement shall serve as the original.
Signature:_____ **Date:**_____

I am aware that at any time I may view the HIPPA and Patient Privacy Policy in the office. **INT.** _____

I know and understand that CFCC is not responsible for loss or damage to personal valuables. **INT.** _____

Consent to Treatment: I consent to Chiropractic treatment and other related services performed on myself or dependent(s) at CFCC. **Signature:** _____ **Date:**_____

I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. **INT.** _____

I hereby authorize direct payment of any medical expense benefits allowable to the doctors at CFCC as payment toward the total charges for professional services rendered. **I agree** that a scanned copy of the agreement shall serve as the original. **Signature:** _____ **Date:**_____

PATIENTS WITHOUT INSURANCE

I understand that payment is to be made at the time of service. We can make financial arrangements, but the TOS discount will not apply to those visits. **Signature:** _____ **Date:**_____

******Notice to new patients:** All fields must be filled out and signed/initialed prior seeing the doctor.

Please Circle either Yes or No where appropriate. Office Use Only: Chart_____ Provider_____

Patient's Name: _____ Date: _____

Please list your present complaints and briefly describe your symptoms: _____

_____

_____

Have you experienced any of these problems prior to the onset of your current symptoms? _____

_____

List all other doctors you have seen for your current conditions: _____

List any activities of daily living that are affected by your conditions (consider your general activities, housework, yard work, personal grooming, travel, etc.)? _____

_____

Have you been treated for any health conditions within the last year? If yes, please describe the conditions and treatment received:__

_____

Please list any previous accidents you have been involved in and their dates: _____

List the frequency and type of exercise you are involved in: _____

Do you Smoke? Yes No If yes, how many Per Day?_____ Per Week? _____

Do you Drink? Yes No If yes, how much Per Day?_____ Per Week? _____

Are you pregnant? Yes No Date of Last Menstrual Period: _____

List any Medications you are taking or have taken within the last 48 hours: _____

_____

List any Allergies: _____

Describe any operations you have had and the dates: _____

_____

Who is your regular physician? _____

Who was your last chiropractor and when was your last visit? _____

Have any family members died from any cause other than old age? If yes, list their relationship to you, their age at time of death, and the cause of their death. _____

_____

Are there any other family members that suffer from the same or similar health problems that are affecting you? Yes No

Do you or any members of your family suffer from any of the following illnesses? (Please Circle) If the illness is relevant for someone other than yourself, please list their relationship to you.

Cancer	Muscular Dystrophy	Rheumatic Fever	Digestive Disorders
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble
Tuberculosis	Convulsions	Nervousness	Backaches
High Blood Pressure	Epilepsy	Asthma	Numbness
Heart Trouble	Concussions	Dizziness	Arthritis
Diabetes	Migraines	German Measles	Venereal Disease
Cerebral Palsy	Hepatitis	Other _____	Other _____

List any family members with physical impairments or mental impairments. (List their age and relationship to you.) _____

_____

Patient's Signature: _____ **Date:** _____

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