1. PATIENT INFORMATION

Date_____

SS/HIC/Patient ID #_____

Patient
Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____ ZIP_____

E-mail_____

Sex M_____ F_____ Age_____

Birthdate_____

____Married ____Widowed ____Single ____Minor

____Separated _____Divorced Partnered for __yrs

Patient Employer/School_____

Occupation_____

Employer/School Address_____
_____

Employer/School Phone ( ) _____

Spouse's Name_____

Birthdate_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you?
_____

2. INSURANCE INFORMATION

Who is responsible for this account?
_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance?

Yes___ No_

Subscribe's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr._____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services. This consent will end when I choose to no longer receive services from Atlantic Chiropractic, LLC.

_____
Signature of Patient, Parent, Guardian or Personal Rep

_____
Please print name of Patient, Parent, Guardian or Personal Rep.

_____ _____
Date Relationship to Patient

3. PHONE NUMBERS

Cell Phone ( )_____

Home Phone ( )_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Home Phone ( )_____

Work Phone ( )_____

4. ACCIDENT INFORMATION

Is condition due to an accident? _____Yes ____No

Date of Accident_____

Type of accident ____Auto ____Work ____Home

_____Other

To whom have you made a report of your accident?

___Auto Insurance ___Employer ___Worker Comp

___Other

_____

Attorney Name (if applicable)

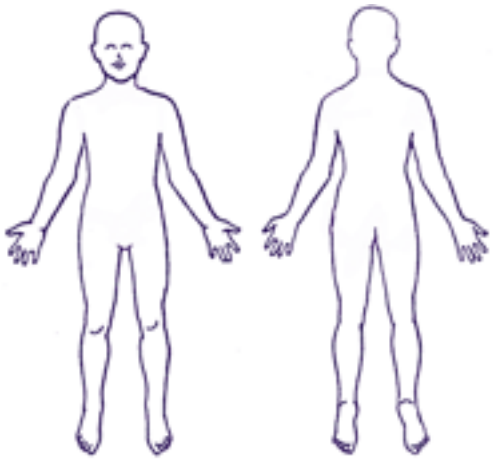
5. PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? _____Yes _____No ____Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain)_____

Type of pain: ___Sharp ___Dull ___Throbbing ___Numbness

___Aching ___Shooting ___Burning ___Tingling ___Cramps

___Stiffness ___Swelling ___Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your ___Work ___Sleep ___Daily Routine ____Recreation

Activities or movements that are painful to perform ___Sitting __Standing __Walking __Bending __Lying down.

6. HEALTH HISTORY

What treatment have you already received for your condition?

___Medications ___Surgery ___Physical Therapy ___Chiropractic Services ___None

Other_____

Name and address of other doctor(s) who have treated you for your condition_____

_____.

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Heart Disease	___Yes ___No	Rheumatoid Arthritis	__Yes ___No
Alcoholism	___Yes ___No	Hepatitis	___Yes ___No		
Allergy Shots	___Yes ___No	Hernia	___Yes ___No	Rheumatic Fever	___Yes ___No
Anemia	___Yes ___No	Herniated Disk	___Yes ___No		
Anorexia	___Yes ___No	Herpes	___Yes ___No	Scarlet Fever	___Yes ___No
Appendicitis	___Yes ___No	High Blood Pressure	___Yes ___No	Sexually Transmitted Disease	___Yes ___No
Arthritis	___Yes ___No				
Asthma	___Yes ___No	High Cholesterol	___Yes ___No		
Bleeding Disorders	___Yes ___No	Kidney Disease	___Yes ___No	Stroke	___Yes ___No
		Liver Disease	___Yes ___No	Suicide Attempt	___Yes ___No
Breast Lump	___Yes ___No	Measles	___Yes ___No		
Bulimia	___Yes ___No	Migraine		Thyroid Problems	___Yes ___No
Bronchitis	___Yes ___No	Headaches	___Yes ___No		
Cancer	___Yes ___No	Miscarriage	___Yes ___No	Tonsillitis	___Yes ___No
Cataracts	___Yes ___No	Mononucleosis	___Yes ___No	Tuberculosis	___Yes ___No
Chemical Dependency	___Yes ___No	Multiple Sclerosis	___Yes ___No	Tumors/ Growths	___Yes ___No
		Mumps	___Yes ___No		
Chicken Pox	___Yes ___No	Osteoporosis	___Yes ___No	Typhoid Fever	___Yes ___No
Diabetes	___Yes ___No	Pacemaker	___Yes ___No	Ulcers	___Yes ___No
Emphysema	___Yes ___No	Parkinson's Disease	___Yes ___No	Vaginal Infections	___Yes ___No
Epilepsy	___Yes ___No	Pinched Nerve	___Yes ___No		
Fractures	___Yes ___No	Pneumonia	___Yes ___No	Whooping Cough	___Yes __No
Glaucoma	___Yes ___No	Polio	___Yes ___No		
Goiter	___Yes ___No	Prostate Problem	___Yes ___No	Other	
Gonorrhea	___Yes ___No	Prosthesis	___Yes ___No	_____	
Gout	___Yes ___No	Psychiatric Care	___Yes ___No	_____	

6. HEALTH HISTORY, CONTINUED

EXERCISE	WORK ACTIVITY	HABITS
__None	__Sitting	__Smoking Packs/Day _____ Did you ever smoke? Y/N
__Moderate	__Standing	__Alcohol Drinks/Week_____
__Daily	__Light Labor	__Coffee/Caffeine Cups/Day _____
__Heavy	__Heavy Labor	__High Stress Level Reason _____

Are you Pregnant? __Yes No__ Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Has any immediate family member had any family history of diseases or disorders?

Relationship	Circle One	Disease or Disorder
Mother	Y/N	
Father	Y/N	
Sister	Y/N	
Brother	Y/N	
Son	Y/N	
Daughter	Y/N	

7. MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

ATLANTIC CHIROPRACTIC OFFICE POLICY

FINANCIAL OBLIGATION

I (the patient) agree that I am financially responsible for payment of all amounts of services provided by Atlantic Chiropractic. I am responsible to pay for my services regardless of insurance coverage or other agreements between Atlantic Chiropractic and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO) or Medicare, I understand that I am financially responsible for non covered services or deductibles, co-pays, or co-insurances as defined in my policy or plan. If the amount I am responsible for is not paid in full within thirty (30) days of receipt of the bill, I agree to pay interest at the rate of 18% Per Annum, billed and compiled monthly at 1.5%. I further agree to pay collection costs up to 50% of the principal debit and the responsible attorney fees and expenses. I give consent for any collection agency to contact me via the information that I have give Atlantic Chiropractic, including, but not limited to, my address, home phone number, and/or cell phone number. I agree to waive venue. This includes patients account balances, and the collection of other expenses related to the patient account balance such as interest, service fees, court costs, and attorney fees. Credit terms are liberally awarded to active patients and strictly enforced with inactive patients.

I understand that Atlantic Chiropractic will provide routine and reasonable insurance claims processing to most carriers as a courtesy for me. In return, they expect cooperation from me, if necessary, to help collect any amounts due.

I understand that Atlantic Chiropractic reserves the right to refuse this courtesy or withdraw it at any time. I understand that Atlantic Chiropractic charges for extraordinary processing, such as reports, copies, or records, etc.

It is understood and agreed that any amounts paid to Atlantic Chiropractic for x-rays are for examination only, the negatives are property of Atlantic Chiropractic, and will remain as part of the permanent patients file.

I understand that Atlantic Chiropractic will not be held responsible for any pre-existing medically diagnosed conditions.

CONSENT TO BILL INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that Atlantic Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is paid directly to Atlantic Chiropractic. I also understand that this amount will be credited directly to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release Atlantic Chiropractic and its employees to administer treatment, physical examination, x-rays studies, laboratory procedures, chiropractic care or any clinic services it deems necessary in my case. I furthermore authorize Atlantic Chiropractic to disclose all or any part of my patient records to any person or corporation which is or may be liable under contract to Atlantic Chiropractic or to me or to a family member or employer of me for all or part of the Atlantic Chiropractic charges, including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

TIMELY APPOINTMENTS

I understand that when I schedule and appointment I am closing off that appointment to other potential patients. Therefore, in order for Atlantic Chiropractic to provide timely service to all patients, I understand that Atlantic Chiropractic requires that if I cannot make it to my appointment and have to cancel for any reason, I will give a 24-hour minimum notice. I agree that I am subject to a $25 office visit fee for failure to provide such notice. Furthermore, I understand that third-payers may not cover this fee.

_____ _____

Patient, parent if minor child, or guardian Date
(If patient is unable to sign. Representative name and relationship)

INFORMED CONSENT DOCUMENTATION

Patient Name:_____

The material risk inherent in Chiropractic adjustments
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains, separation, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risk occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check during the taking of the history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustment. The other complications are also generally described as rare.

The availability and nature of other treatment options
Other treatment options for your condition may include:
***** Self-administered, over-the-counter analgesics and rest
***** Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
***** Hospitalization
***** Surgery
If you choose to use one of the above noted “other treatment” options, you should be aware that there are risk and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the chiropractor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment.

_____ _____

Patient’s Name **Date** **Doctor’s Name** **Date**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)