

1

ABOUT YOU

Today's Date: ___/___/___ File # _____

Patient Name: _____
LAST FIRST MI

What Do You Prefer To Be Called: _____

Male Female

Birthdate: ___/___/___ Age: _____ SS# _____

Mailing Address : _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouses Name: _____

S.S.# _____ Date of Birth _____

Do you have children? Yes No How Many? _____

3

REASON FOR VISIT

The reason for this visit is a result of (Please Circle):
work, sports, auto, trauma or chronic.

(Explain what happened): _____

Please describe the pain & its location: _____

When did condition begin? ___/___/___

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (Please Circle): work, sleep, or daily routine

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____

2

INSURANCE INFO

Primary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Secondary Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #) _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer _____

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone #: _____

Payment method: CASH CHECK

Credit Card - Enter card # above (if accepted)

Initials I hereby authorize assignment of
my insurance rights and benefits directly to
the provider for services rendered. I fully
understand I am solely responsible for any
balance not paid by my insurance company (if
offered at this office).

4

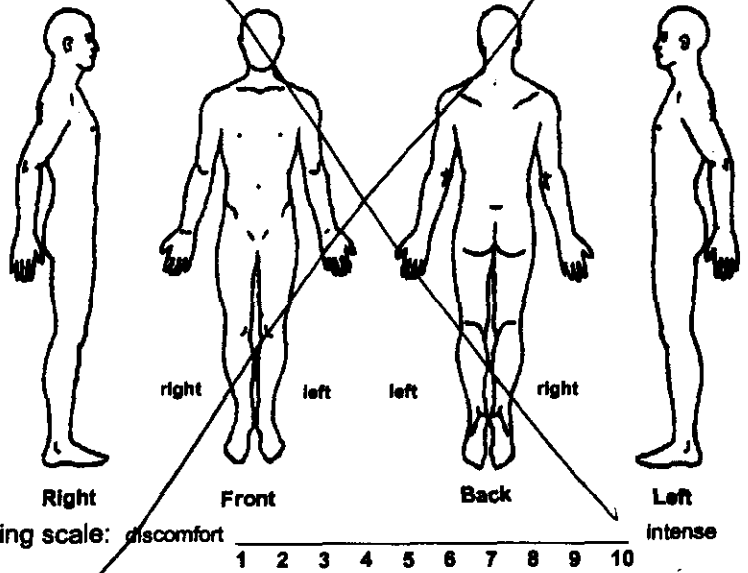
IN EVENT OF EMERGENCY

Who should we contact? _____
 Relation: _____
 Home Phone #: _____
 Work Phone #: _____
 Who is your Medical Doctor? _____
 M.D.'s Phone #: _____

5

See next page

Using the adjacent body charts, please circle all affected areas.



6

HEALTH HISTORY

Are you taking any of the following medications? Nerve pills Pain killers (including aspirin) Muscle relaxers
 Blood thinners Tranquillizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|-----------------------------|--------------------------------|-------------------------|--------------------------------------|---------------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N HIV+ / AIDS / ARC |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Anemia / Diabetes |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever | Y N Severe/Frequent Headaches | Y N Kidney Problems |
| Y N Ulcers / Colitis | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Emphysema / Asthma | Y N Tuberculosis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N Arthritis |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since: ____/____/____

For Women: Are you taking Birth Control? Yes No Are you Nursing? Yes No

Are you Pregnant? No Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.


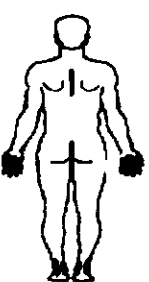
UPDATE (office use)

Initials _____ Date _____
 Comments _____
 Initials _____ Date _____
 Comments _____
 Initials _____ Date _____
 Comments _____


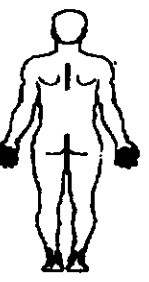
Signature _____ Date ____/____/____
 Adult Patient Parent or Guardian Spouse

Please Fill Out the Information Below, and circle all that apply to the problems you experience
(If you need help please ask the front desk)



Main Health Concern 1)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling Muscle	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, burning, Migraine, tension, hormonal, sinus, Other			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time _____	Mild, Tolerable, Moderate, Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious	Spasms Headache Tension Tingling						

Main Health Concern 2)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling Muscle	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, burning, Migraine, tension, hormonal, sinus, Other			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermittent Occasion Infrequent % Awake Time _____	Mild, Tolerable, Moderate, Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious Other _____	Spasms Headach Tension Tingling						

Main Health Concern 3)

Onset Date	How:	Type:	Quality	Front	Back	Radiating	Timing	Severity
_____	Trauma Repetitive Unknown	Pain Numb Swelling Muscle	Sharp, Dull, aching, throbbing, crushing, stabbing, local, radiating, burning, Migraine, tension, hormonal, sinus, Other			Cerv Mid Back Lumbar L/R Leg L/R Arm Other	Constant, Frequent Intermitt Occasion Infrequent % Awake Time _____	Mild, Tolerable, Moderate, Severe, Disabling /10
Flare Up/ Made Worse	Post Surgical Work Auto Insidious Other _____	Spasms Headach Tension Tingling						

NOTES: (For Office Use Only)

Dahlonega Chiropractic Life Center

INSURANCE POLICY

In order to accommodate the need and requests of our patients, we are enrolled and participate in numerous insurance plans and networks so that our patients can take advantage of any in-network chiropractic benefits available. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all of the individual requirements for these plans. Each carrier and plan has different stipulations regarding its policies.

IT IS YOUR RESPONSIBILITY to contact your insurance company and find out whether or not our doctor is a participating physician with your particular insurance plan. Some insurance carriers have PPO, HMO, POS or indemnity status, and it is very possible that our doctor may participate in only one of these areas and not in all.

IT IS YOUR RESPONSIBILITY to give Dahlonega Chiropractic Life Center correct insurance information to obtain the proper referral or pre-authorization (if applicable). If you fail to do so, you are responsible for payment.

IT IS YOUR RESPONSIBILITY to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your individual insurance policy.

IN THE EVENT THAT:

1. Insurance coverage is denied because we are not a participating physician in your plan;
2. Insurance coverage is not in effect on the date of your visit;
3. A non-covered service is performed or denied:

You will be billed directly for all charges related to your office visit.

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT HAVE INSURANCE, PAYMENT IN FULL IS EXPECTED UNLES OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.

AUTHORIZATION TO PAY DOCTOR/CLINIC

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT THE RESPONSIBILITY AS DESCRIBED.

I HEREBY AUTHORIZE & DIRECT PAYMENT OF ANY MEDICAL EXPENSE BENEFITS ALLOWABLE TO THE DOCTOR/CLINIC NAMED ABOVE AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. I AGREE THAT A PHOTOSTATIC COPY OF THIS AGREEMENT SHALL SERVE AS THE ORIGINAL.

DOCTOR/CLINIC

Dahlonega Chiropractic Life Center
131 Mechanic Street / P. O. Box 599
Dahlonega, GA 30533
706-864-5362

SIGNATURE

DATE



DR. G. TODD HOLUBITSKY
131 Mechanic St., P.O. Box 599
Dahlonaga, Ga 30533
Ph. 706-864-5362
Fax: 706-864-5761

AUTHORIZATION OF RELEASE

Date

I HEREBY AUTHORIZE & REQUEST THE RELEASE OF ANY AND ALL INFORMATION, HISTORY, RECORDS AND X-RAYS OR COPIES OF SUCH. I ACCEPT FULL RESPONSIBILITY FOR MY X-RAYS.

PATIENT NAME (Printed)

PATIENT DATE OF BIRTH

ADDRESS

CITY, STATE & ZIP

X _____
PATIENT SIGNATURE

ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S PRIVACY PRACTICES AS OUTLINED BY THE H.I.P.P.A. PRIVACY NOTICE EFFECTIVE APRIL 14, 2003.

X _____
PATIENT SIGNATURE