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?

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 ____________________________

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? ____

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)

___________I hereby authorize assignment of
Initials
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.

Right — Front (right, left) — Back (left, right) — Left

Rate your pain with the following scale: discomfort ______ intense

1 2 3 4 5 6 7 8 9 10

6 HEALTH HISTORY

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ 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.

Signature ______________________ Date ____/____/____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

UPDATE
(office use)

_______ Initials ____/____/____ Date

_______ Comments

_______ Initials ____/____/____ Date

_______ Comments

_______ Initials ____/____/____ Date

_______ Comments

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	Pain	Sharp, Dull, aching, throbbing,		Cerv	Constant,	Mild,
	Repetitive	Numb	crushing, stabbing,		Mid Back	Frequent	Tolerable,
	Unknown	Swelling	local, radiating,		Lumbar	Intermitt	Moderate,
Flare Up/ Made Worse	Post Surgical	Muscle Spasms	burning, Migraine,		L/R Leg	Occasion	Severe,
	Work	Headache	tension, hormonal,		L/R Arm	Infrequent	Disabling
	Auto	Tension	sinus, Other		Other	% Awake	
________	Insidious	Tingling				Time____	/10

Main Health Concern 2) ____________________

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

Main Health Concern 3) ____________________

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

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
Dahlonega, 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

_______________________ X_______________________
CITY, STATE & ZIP **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