

# WELCOME

Date: \_\_\_\_\_

## *Patient Information*

Name: \_\_\_\_\_  
Last First MI

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Other) \_\_\_\_\_

Can we call you at work?  Yes  No

Date of Birth: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Race:  Caucasian  African American  Asian  Native American  Latin American  Other

Ethnicity:  Hispanic  Latino  Non-Hispanic / Non-Latino

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

**General Allergies & Medication Allergies:** \_\_\_\_\_

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## *Accident Information*

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other \_\_\_\_\_

Has it been reported?  Yes  No If yes, to whom? \_\_\_\_\_

## *Insurance Information*

Please provide this office with a copy of your insurance card(s)

If your insurance company does not cover your treatment plan would you be willing to pay out of pocket to alleviate this condition? Yes \_\_\_\_\_ No \_\_\_\_\_

**HEALTH HISTORY (Must Fill Out All Portions of History)**

**What is the main reason you are seeking treatment?** \_\_\_\_\_

**When did the problem begin?** \_\_\_\_\_

**Treatments Received for the Problem(s):**

|                                       |                     |
|---------------------------------------|---------------------|
| MRI/CT Scan _____                     | When _____          |
| Surgery _____                         | When _____          |
| Medication _____                      | When _____          |
| Epidurals/Injections _____            | How Many/When _____ |
| Physical Therapy _____                | When _____          |
| Chiropractic _____                    | When _____          |
| Bracing/Splint prescribed by MD _____ | When _____          |

Please describe what you think will happen if the problem gets worse:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check to indicate if you have experienced any of the following conditions in the last ONE month:**

- |  |   |
|--|---|
| <input type="checkbox"/> Neck pain/stiffness   | <input type="checkbox"/> Headaches/ Migraines             |
| <input type="checkbox"/> Weakness, numbness or burning in your shoulders, arms, hands      | <input type="checkbox"/> Jaw problems                     |
| <input type="checkbox"/> Pain that radiates down arms                                      | <input type="checkbox"/> Blurred vision/light sensitivity |
| <input type="checkbox"/> Reduced feeling (sensation) or swelling in your hands or arms     | <input type="checkbox"/> Loss of smell/ taste             |
| <input type="checkbox"/> Loss of handgrip strength   | <input type="checkbox"/> Seasonal allergies               |
| <input type="checkbox"/> Low back or mid back pain/stiffness                               | <input type="checkbox"/> Dizziness                        |
| <input type="checkbox"/> Weakness, numbness or burning in your buttocks, legs or feet      | <input type="checkbox"/> Nausea/vomiting                  |
| <input type="checkbox"/> Pain that radiates down legs                                      | <input type="checkbox"/> Fatigue/lack of energy           |
| <input type="checkbox"/> Reduced feeling (sensation) or swelling in your legs, feet        | <input type="checkbox"/> Sleeping Difficulties            |
| <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Bowel/bladder changes            |
| <input type="checkbox"/> Frequent falls or find that you trip over your feet while walking | <input type="checkbox"/> Stomach problems                 |
|  | <input type="checkbox"/> Sudden weight loss               |

**Please check to indicate if you have or have ever had any of the following conditions:**

- |   |   |   |  |   |
|---|---|---|--|---|
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Blood clot     | <input type="checkbox"/> Migraines      | <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Fractures      | <input type="checkbox"/> Liver disease   | <input type="checkbox"/> Hepatitis A,B,C      |
| <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Kidney disease  | <input type="checkbox"/> AIDS/HIV             |
| <input type="checkbox"/> Pacemaker/defib. | <input type="checkbox"/> Pinched nerve  | <input type="checkbox"/> Gout           | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> High cholesterol |   |   |  |   |

**HEALTH HISTORY CONTINUED**

Who is your primary care Doctor? \_\_\_\_\_

All Medications currently taking (including supplements): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicines previously tried for pain?  Advil  Aleve  Tylenol  Steroids  Prescriptions \_\_\_\_\_  
- For how long?  0-3mos,  3-6mos,  6-12mos,  12+mos

Previous Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_  Other \_\_\_\_\_

Cancer \_\_\_\_\_  Arthritis \_\_\_\_\_  Other \_\_\_\_\_

Intake of following: Cigarettes \_\_\_\_\_ packs/day Alcohol \_\_\_\_\_ drinks/week Caffeine \_\_\_\_\_ cups/day

Exercise frequency:  Never  Daily  Weekly  Walks  Runs  Swims  Other \_\_\_\_\_

Does work mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

**X-ray Questionnaire**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. I \_\_\_\_\_, authorize North Cobb Spine and Nerve Institute to take any necessary x-rays.

Signatures: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR WOMEN ONLY!!**

- There is a possibility that I may be pregnant at this time.
- Yes, I am definitely pregnant.
- No, I am definitely not pregnant at this time.
- I request that x-ray films not be taken because \_\_\_\_\_

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS  
AS WELL AS AN  
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND  
A BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay North Cobb Spine and Nerve as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

X \_\_\_\_\_  
(Patient signature)

Date: \_\_\_\_\_

X \_\_\_\_\_  
(Please print patient name)

X \_\_\_\_\_  
(Signature of Guardian if applicable)

**INFORMED CONSENT TO CARE**

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X\_\_\_\_\_ I have read and understand the above consent form.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have reviewed the Notice of Privacy Practices of North Cobb Spine and Nerve. (Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X\_\_\_\_\_ Signature of Patient/Guardian

\_\_\_\_\_ Date

X\_\_\_\_\_ Witness (Office Staff)

\_\_\_\_\_ Date



**NORTH COBB  
SPINE & NERVE INSTITUTE**  
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Phone: (678) 574-5678 Fax: (678) 574-5605 [NorthCobbSpine@yahoo.com](mailto:NorthCobbSpine@yahoo.com)

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Date: \_\_\_\_\_

Requesting Physicians: Xanthia Settle, NP-C

I, \_\_\_\_\_ (print name) have requested the release of X-Rays and/ or medical records which are part of the office records of New Life Chiropractic Center relating to my case. I hereby acknowledge receipt of these X-Ray films and medical records. In consideration of the foregoing. I hereby release and forever discharge the aforesaid New Life Chiropractic Center from any and all responsibility of any kind relating to these x-rays and/ or medical records.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness