INJURY 2 HEALTH

Patient ID: _____

New Patient Questionnaire

Name (print): _____ Date: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

[ ] Male [ ] Female [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Birthdate: _____ Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____ Yrs: _____

Employer: _____ Occupation: _____

Bus. Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent Name: _____ Birthdate: _____ Phone: _____

Who may we thank for referring you? _____

How did you hear about us? _____

Name of Local/Primary Physician: _____ May we contact them? _____

Insurance information – if insured, please provide a copy of your insurance card.

Symptoms: Main complaint: _____ How bad? _____ How often? _____

Date pain started: _____ Getting worse? _____ Getting better? _____

What activity bothers you the most? _____

When is it at it's best? _____ When is it at it's worst? _____

Rate the pain: (0 is pain free and 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Have you ever seen another Chiropractor? _____ Positive experience? _____

Have you seen another Physician or Therapist? _____ Positive experience? _____

Health History (please circle all that apply)

AIDS/HIV	Breast Lumps	Emphysema	Hepatitis	Migraines	Pace Maker	Tonsilitis
Allergy Shots	Bronchitis	Epilepsy	Hernia	Miscarriage	Pneumonia	Tuberculosis
Anemia	Bulimia	Fractures	Herniated Disc	Mono	Prostrate Dx	Tumors
Anorexia	Cancer	Glaucoma	Herpes	M.S.	Prosthesis	Typhoid
Appendicitis	Cataracts	Goiter	High Cholesterol	Mumps	Implants	Ulcers
Arthritis	Chicken Pox	Gonorrhea	Kidney Disease	Osteoporosis	Rheumatoid A	Venereal Dx
Asthma	Depression	Gout	Liver Disease	Parkinson's	Stroke	Whooping Cough
Bleeding	Diabetes	Heart Disease	Measles	Polio	Thyroid Dx	Chronic Fatigue
High BP	Fibromyalgia	Other: _____				

Women: How many children?____ Pregnant? [ ] Yes [ ] No Nursing? [ ] Yes [ ] No

Date of last menses: _____ Taking birth control pills? [ ] Yes [ ] No

*All Patients: Surgeries and Dates: _____

Medications: List all you are currently taking: _____

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Supplements: List all you are currently taking: _____

What exercises do you do? _____

Do you smoke? _____ How much? _____ Do you drink? _____ How much a day? _____

I have answered the above questions accurately and to the best of my ability and knowledge. I understand that giving incorrect information can be dangerous. I authorize this Clinic to release any information pertaining to my treatment to third party payers or other healthcare providers. I authorize and request my insurance company to pay directly to this Clinic any payable benefits.

_____ _____ _____

Patient/Guardian Signature Date Witness Signature

INJURY 2 HEALTH
Dr. Ellie Tillman
3655 Cherokee St. NW
Suite #5
Kennesaw, GA 30144
(770) 426-6639

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physical therapy and diagnostic X-rays on me (or the name of the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic whose name appears below and/or other licensed Doctors of Chiropractic care, who now or in the future treat me while employed by, working for or associated with, by serving as back-up for the Doctor of Chiropractic named above, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the Doctor of Chiropractic whose name appears below and/or with any other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have had an opportunity to discuss with the Doctor of Chiropractic and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and have been informed that the practice of medicine, in particular, the practice of chiropractic care there are some risks to treatment, including but not limited to, fracture disc injuries, stroke, dislocations and sprains. I do not expect the Doctor to be able to anticipate and explain all the risks and complications. I wish to rely on the Doctor to exercise judgement during the course of procedure which the Doctor feels at the time, based on facts known at the time and in my best interest.

I have read and/or have had read to me the consent above. I have had an opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

<u>To be completed by the Patient or the Patient's Representative, if necessary. For example, If the patient is a minor or physically or legally incapacitated.</u>

_____	_____	_____
Print Patient's Name	Patient's Signature	Date
_____	_____	_____
Patient's Representative	Relationship	Date
_____	_____	
Witness Signature	Date	

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_____ _____
Patients Name (printed) Date

DOCTOR/PATIENT RESPONSIBILITY

Injury 2 Health is treating you while waiting for payment from your insurance company. We do this because we understand that you need care now. Please respect this gift of time that we are providing to you.

I understand it is my responsibility to Injury 2 Health to inform the Doctor and Staff when a Settlement Date has been determined. I also understand that it is my responsibility as a patient to verify any/all outstanding balances owed to Ballard Chiropractic Clinic.

I respectfully acknowledge at the time of settlement with my insurance company all monies owed to Injury 2 Health for services rendered are due and payable.

I have read and agree/accept this document as written: _____
Patient Initials

_____ _____
Patient or Guardian Signature Date

_____
Witness Signature

INJURY 2 HEALTH
Dr. Ellie Tillman
3655 Cherokee St. NW
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Kennesaw, GA 30144
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_____ _____

Patient's Name (Printed) Date

AUTHORIZATION AND RELEASE

I authorize the doctor and staff named above to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney adjustor or family member in order to process any/all claims for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release the doctor and staff of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

_____ _____

Patient or Guardian Signature Witness Signature

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any/all medical and surgical expense benefits allowable to the doctor and clinic named above as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor and clinic. I agree that a photostatic copy of this agreement shall serve as the original.

_____ _____

Patient or Guardian Signature Witness Signature