# 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**:_____________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## 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 (<u>Must Fill Out All Portions of History</u>)**

**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 <u>ONE</u> month:**

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

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

| | | | | |
|---|---|---|---|---|
| ❑ Hypertension | ❑ Blood clot | ❑ Migraines | ❑ Osteoporosis | ❑ Rheumatoid Arthritis |
| ❑ Diabetes | ❑ Stroke | ❑ Fractures | ❑ Liver disease | ❑Hepatitis A,B,C |
| ❑ Heart disease | ❑ Herniated disc | ❑ Osteoarthritis | ❑ Kidney disease | ❑AIDS/HIV |
| ❑Pacemaker/defib. | ❑ Pinched nerve | ❑ Gout | ❑ Thyroid problem | ❑ Other___________ |
| ❑High cholesterol | | | | |

## HEALTH HISTORY CONTINUED

Who is your primary care Doctor? ______________________________________________

**All** Medications current ly 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 NCSN 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 or this document is to be considered as valid and as enforceable as the original.

X______________________________________________ Date: ____________
(Patient signature)

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 NCSN.
(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