SAMUELS CHIROPRACTIC HEALTH CLINIC

4840 Roswell Road, Suite C-100
Atlanta, GA 30342

Phone: 404.843.3040 Fax: 404.843.0119 Email: samuelschiro@bellsouth.net

NEW PATIENT INFORMATION

Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Cell Phone/Pager _____

Email Address _____

Date of birth _____/_____/_____ Sex ____ Social Security_____-_____-_____

Marital status _____ Occupation _____

Employer_____
Name Street City State Zip

Work Phone _____ Work Fax _____

Emergency contact _____ Phone _____/_____

Relationship _____ Referred by _____

Main Symptom _____ Date Symptom Occurred _____

Have you had this symptom before? _____ If yes, when? _____

OFFICE POLICY

Payment is due in full at the time of your visit. Please see our Financial Policy. We will provide you with a receipt to send to your insurance company for reimbursement. Your insurance company will reimburse you directly.

We require a minimum of 24 hours advance notice to cancel an appointment. By not canceling your appointment in advance, you are denying others of health care. **Please note, we reserve the right to charge the full fee for all missed appointments not canceled with 24 hours notice.**

Insurance companies will not reimburse for missed visits.

I understand the Office Policy of Samuels Chiropractic Health Clinic as stated.

_____
Patient signature Date

SAMUELS CHIROPRACTIC PERSONAL HEALTH HISTORY

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition responds satisfactorily to treatment, we will not recommend treatment

Name	Birth Date	Age	Today's Date	Case Number

Please check the degree of all conditions that you have or have had. We need your complete health report before we can be responsible for your care.

I = Irregular R = Regular S = Steady

Muscle/Joint

I	R	S	
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain, stiffness
☐	☐	☐	Pain between shoulders

General

I	R	S	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness, depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
☐	☐	☐	Neck pain, stiffness

Cardiovascular

I	R	S	
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heartbeat
☐	☐	☐	Slow heartbeat
☐	☐	☐	Swelling of ankles

Genitourinary

I	R	S	
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Lack of kidney control
☐	☐	☐	Kidney infection
☐	☐	☐	Painful urination
☐	☐	☐	Prostrate trouble
☐	☐	☐	Pus in urine

Eye, Ear, Nose and Throat

I	R	S	
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noise
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nose bleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

Gastrointestinal

I	R	S	
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Bloated abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gallbladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

Skin

I	R	S	
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

Pain or numbness in

I	R	S	
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tailbone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

Respiratory

I	R	S	
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

Women only

I	R	S	
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excess menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycles
☐	☐	☐	Lumps in breast
☐	☐	☐	Menopause
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

Are you pregnant? ☐ Yes ☐ No
If yes, how long? _____ months
Number of children _____

Check any of the following conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Breast implants
- ☐ Cancer
- ☐ Chicken pox
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Chiropractic Problem ***(Describe)***

How long have you had this condition?	Is it getting worse? ☐ Yes ☐ No	Does it bother your ☐ Work ☐ Sleep ☐ Other *(specify)*	
What seemed to be the initial cause?			
Have you seen a Chiropractor before? ☐ Yes ☐ No	If yes, how long ago?	For what reason?	
Are you under the care of a physician? ☐ Yes ☐ No	If yes, for what?		
Have you been in the hospital in the last five years? ☐ Yes ☐ No	For major surgery? ☐ Yes ☐ No	For serious injury? ☐ Yes ☐ No	Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?

SAMUELS CHIROPRACTIC PERSONAL HEALTH HISTORY CONT.

Drugs you now take: ☐ Birth control pills ☐ Tranquilizers ☐ Pain killers ☐ Other *(specify)*

Do you wear? ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ☐ Negative heels ☐ Platform shoes

Age of your mattress? ☐ Comfortable ☐ Uncomfortable

Do you use a bedboard? ☐ Yes ☐ No

How is most of your day spent? ☐ Standing ☐ Sitting ☐ Walking ☐ Other *(specify)*

Have you ever:	Yes	No	If yes, briefly explain:
Had a broken bone?	☐	☐	
Been hospitalized?	☐	☐	
Had strains or sprains?	☐	☐	
Used a cane, crutch or other support?	☐	☐	
Been struck unconscious?	☐	☐	
Been hospitalized for more than surgery?	☐	☐	

Do you?		
Take minerals, herbs or vitamins?	☐	☐
Think you need minerals, herbs or vitamins?	☐	☐
Have any drug allergies?	☐	☐

When did you last have?	Never	0 – 6 mo	6 – 18 mo	Longer
Spinal x-ray?	☐	☐	☐	☐
Spinal examination?	☐	☐	☐	☐
Physical Examination?	☐	☐	☐	☐

Please list any other health conditions you have been treated for or surgery you have had in the last 10 years:

Habits	None	Light	Mod.	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar products	☐	☐	☐	☐
Artificial sweeteners	☐	☐	☐	☐

Family Health Information

Some health conditions are the result of hereditary spinal weakness. Information about your immediate family members, including brothers, sisters, parents and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Summary *(Doctor's use)*

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PAIN CHART

ABOUT YOU:

Name

_____

First Middle Last

Please describe your condition:

_____

_____

_____

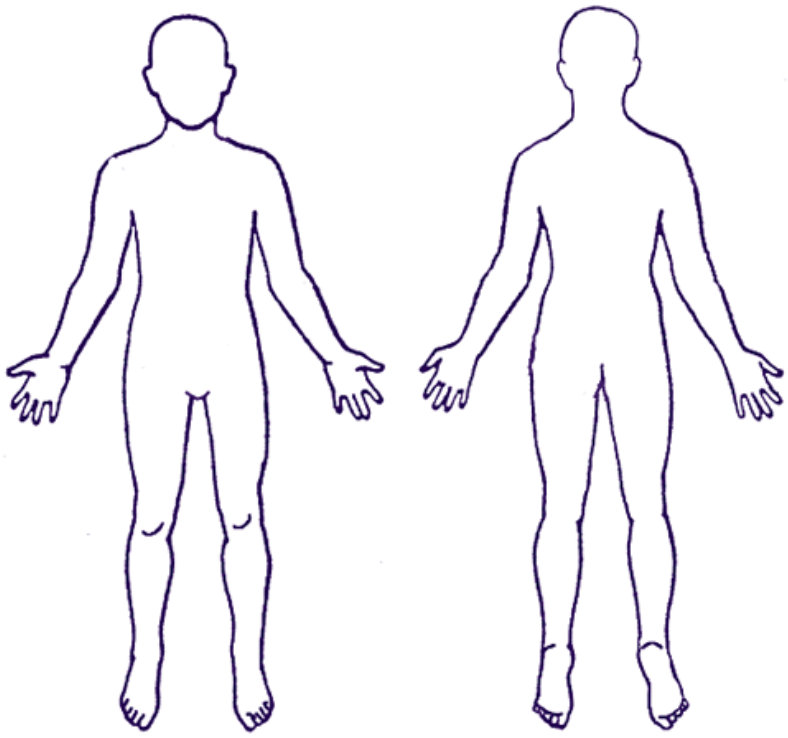
_____

Patient signature Date

SHOW US WHERE IT HURTS:

Please mark area(s) of injury or discomfort using the appropriate symbols.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
- - - - - - -	i i i i i	^ ^ ^ ^ ^	X X X X	0 0 0 0



DOCTOR'S NOTES:_____

_____

_____

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CONSENT TO CHIROPRACTIC SERVICES

1. I _____, authorize the performance upon myself of the following procedure(s) to be performed by or under the direction of Dr. Carol A. Samuels.

    a. X-rays
    b. To the best of my knowledge I am not pregnant _____
    (signature)
    c. Spinal manipulations/ extremity manipulations
    d. Muscle testing for diagnostic purposes
    e. Nutrition evaluation
    f. Other _____
    _____

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether arising from presently unforeseen conditions, that the above named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences and the possibility of complications have been explained to me by the above named doctor and her associates or assistants.

4. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure have been given by the above named doctor or her associates or assistants.

_____

Signature Date

_____

Witness Date

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the Samuels Chiropractic Health Clinic, PC (the Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/e-mail address:

_____

_____

_____

The Practice may communicate confidential information about me to the following individual(s):

_____

_____

Patient/Patient Representative Date

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment is considered a part of your treatment. The following is a statement of our *Financial Policy,* which we require you to read and sign prior to any treatment.

All patients must complete all of our *Patient Information* before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF THE SERVICE.
WE ACCEPT CASH, CHECKS, VISA/MASTERCARD

We feel it is necessary that the patient understand their medical problem and their financial arrangements with our office. We cannot render quality medical care on the assumption that our charges will be paid by an insurance company. Either the patient or responsible party is financially responsible for all charges at the time of the visit to our clinic. We will prepare any necessary information on an itemized claim form. If you need additional copies of this claim form please inform the office manager at the time of your visit, as additional copies are not available later. If you need additional forms, letters or reports written to your insurance company there will be an additional charge based on the time spent and research involved.

REGARDING INSURANCE

We **do not** accept assignment of insurance benefits as payment for your chiropractic visits. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract.

According to Georgia legislation, benefits should be paid within two weeks following receipt of a claim form or the insurance company is committed to provide an explanation of delinquency to the INSURED. Please contact your insurance representative if you have not been notified of payment of a claim within four weeks following the submission of the claim. **Please note: our office does not accept assignment from Medicare.**

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

X-RAYS

There will be a fee charged by our office to interpret any x-rays or MRI's brought in by our patients. This fee will begin at $25.00 per set of films, to be reviewed. We do not have the equipment here at our facility to take films and process them, but we will be happy to read x-rays or MRI's taken at other facilities for our above-mentioned fee.

ADULT PATIENTS

Adult patients are responsible for full payment at the time of service.

MINOR PATIENTS

A parent must accompany minor patients or legal guardian to each visit or non-emergency treatment will be denied. The adult accompanying the minor and the parents will be responsible for full payment at the time of each visit.

MISSED APPOINTMENTS

Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

_____

Signature Date

_____

Witness Date