CUMMING CHIROPRACTIC CENTER

PATIENT INTRODUCTION CARD

Child 14 and under

Date_____

Name_____Social Security#_____
Last First Middle

Address_____City_____State_____Zip_____

Home #_____ Cell #_____ Work #_____

Which would you prefer, email reminders or a text message for future appointments? (Circle one) Email Text message

Email address_____ Text message - Phone carrier_____

Would you like your appointment reminder 4 hours or 1 day before appointment? (circle one) 4 hours 1day

Age_____Birthdate_____#Siblings/Ages_____

Mother_____Cell_____Father_____Cell_____

Name of School_____ Sports / Activities_____

Do you have health insurance?_____ What company?_____

Who is the primary insured?_____ Insured's Date of Birth _____

Difficulties with birth process? ☐ Yes ☐ No ☐ Premature ☐ Full Term_____

☐ Natural ☐ Epidural ☐ C-Section ☐ Forceps ☐ Extraction (suction cups) ☐ Other_____

Describe health concerns in detail, how it happened and your pain level (mild 1 2 3 4 5 6 7 8 9 10 severe)

_____

_____

Date symptoms occurred?_____ Ever had similar symptoms? ☐ Yes ☐ No

Is condition related to auto accident? ☐ Yes ☐ No

Referred by_____

Describe care received before coming to this office and results_____

Have you had chiropractic before?_____ Where?_____When?_____

Do you wish spinal correction or temporary relief of your condition? ☐ Correction ☐ Temporary Relief

Have you ever had surgery? ☐ Yes ☐ No If yes, please explain (give month & year) _____

_____

Are you presently taking any medication? ☐ Yes ☐ No If yes, please give type, dosage and what it is for _____

_____

Have you ever had any falls, accidents or injuries? ☐ Yes ☐ No If yes, please explain (give month & year)_____

_____

Describe injured area(s)_____

I authorize Dr. Joseph Gregory, D.C. and whomever he may designate as his assistant to administer chiropractic care as he deems necessary to my child, _____.

_____

Date Parent or Guardian Signature Relationship

Patient Name: _____ ID#: _____

Date: _____

REVIEW OF SYSTEMS

Please write in a number: 1. PRESENTLY HAVE; 2. PREVIOUSLY HAD; 3. DUE TO CURRENT INJURY (Date:_____)

GENERAL
___Cancer
___Stroke
___Broken Bones
___Cortisone Use
___High Blood Pressure
___Siezures / Eplepsy
___Diabetes
___Headache
___Dizziness/Fainting
___Unexplained Weight Loss
___Drug or Food Allergy
___Excessive Thirst
___Constant Fatigue
___Night Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/Frequent Ringing in Ears
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Worsening vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Tendonitis
___Hernia
___Low back Pain, Soreness or Stiffness
___Mid-Back Pain, Soreness or Stiffness
___Neck Pain, Soreness or Stiffness
___Shoulder Blade Pain, Soreness or Stiffness
Pain or numbness in:
___*Shoulders*
___*Arms*
___*Elbows*
___*Hands*
___*Hips*
___*Legs*
___*Knees*
___*Feet*
___Painful tailbone
___Poor Posture
___Sciatica
___Scoliosis

GENITO-URINARY
___Urgent Sensations to Urinate
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular Menses
___Lumps in Breasts

CARDIOVASCULAR
___Hardening of arteries
___Low blood pressure
___Dizziness
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

OTHER

_____

_____

_____

_____

_____

Employment, Activities of Daily Living (ADL's) and Recreation Information

Patient Name: _____ Date: _____

Description of Work: _____

Condition's Effect On Job Performance:

☐ No Effect ☐ Mild Painful (Can do) ☐ Mod Painful (Limited) ☐ Severe (Unable to Perform)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Care- Infirm Family:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Change Pstn Sit to Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Feeding:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lift Children:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Pet Care:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Shaving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

Recreational Activity: Effects of Current Condition on Performance

_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

(Examples: running, golfing, bowling, tennis, shopping, water sports, cycling, football, basketball, weight train, aerobics, biking, swimming, hunting, fishing, gardening, etc.)

Cumming Chiropractic Center

Authorizations and Release

Name: _____ Birthdate_____

Financial Agreement

Before the Doctor(s) of Cumming Chiropractic Center can provide you with their services, it is important that all financial arrangements be clearly understood. Our agreement for your health care is with you alone. Your insurance is not a part of this agreement. Policy benefits vary from company to company and from policy to policy within each company, you are advised that you may or may not be fully compensated under the provisions of your own insurance policy. Please note that the carrying of insurance by us is done as a courtesy to our patients. While insurance claims are being processed, your co-insurance/payment is due at the time of service.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature_____ Date ____/____/_____ Witness_____

Medical Information Authorization to Release

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____ Date ____/____/_____ Witness_____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to *Cumming Chiropractic Center* the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ Date ____/____/_____ Witness_____

Acknowledgement of Receipt of Notice of Patient Privacy Practices

I have read or been provided with a Notice of Patient Privacy Practices that provides a description of healthcare information uses and disclosures, I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Patient's Signature_____ Date ____/____/_____ Witness_____

No Accident or Work Injury / No Secondary Insurance

I, the undersigned, state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of any injury while on the job or by any other person related to my employment.

I, also, state that I am not insured under any additional (secondary) health insurance policies.

Patient's Signature_____ Date ____/____/_____ Witness_____

Consent for Treatment of Minor (under age 18)

I hereby authorize the Doctors of *Cumming Chiropractic Center* and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____ (indicate relationship to child) _____(Child's name).

Guardian's Signature_____ Date ____/____/_____ Witness_____

Cumming Chiropractic Center

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cumming Chiropractic Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

Cumming Chiropractic Center **Medical Records Authorizations**

Name: _____ DOB_____

Medical Information Release Form (HIPAA Release Form)

I authorize to release my medical records to the person(s) or organization listed below:
I hereby request and authorize you, your employees and agents of Cumming Chiropractic Center to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Name of person(s) medical record may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call my [ ] home [ ] work [ ] cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Patient's Signature_____ Date ____/____/_____

Witness_____ Date _____/ _____/_____

CUMMING CHIROPRACTIC CENTER

299 Canton Road
Cumming, Georgia 30040
Dr. Jason M. Gregory

www.drjasongregory.com

Phone: (770) 889-2208

Fax: (770) 889-0277

I give Cumming Chiropractic Center permission to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Parent or Guardian Signature:

_____

Date: _____

I decline the right to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Parent or Guardian Signature:

_____

Date: _____

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Dr. Jason Gregory, D.C.
www.drjasongregory.com

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Cumming Chiropractic Center reserves the right to charge a fee of $25 for all missed appointments, "no shows", and appointments without a compelling reason, are not cancelled with a 24-hour notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name _____ Date _____

Signature _____

Thank you for understanding.