

**Loving Care Family Chiropractic**  
925 Main Street Suite 108 Stone Mountain, GA 30083  
Tel (678) 476-3778 Fax (770) 938-2927

**CONFIDENTIAL PATIENT INFORMATION**

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

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell No: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital: M S W D How Many Children: \_\_\_\_\_ E-Mail: \_\_\_\_\_

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ D/O/B: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Patient's Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Have you ever Treated with us before? \_\_\_\_\_

Purpose of This Appointment: \_\_\_\_\_

Other Doctors Seen For This Condition: \_\_\_\_\_

DATE OF: Last Physical Exam \_\_\_\_\_ Last Chiropractic Exam \_\_\_\_\_ Last Menstrual Cycle \_\_\_\_\_

Are you pregnant? YES NO

Have you been treated for any health condition by a physician in the last year? YES NO When? \_\_\_\_\_

Describe: \_\_\_\_\_

List all Surgeries and Dates: \_\_\_\_\_

Serious Illness: \_\_\_\_\_

**HAVE YOU EVER SUFFERED FROM**

- |                         |                        |                                |
|-------------------------|------------------------|--------------------------------|
| 1. Dizziness: _____     | 5. Tuberculosis: _____ | 11. Digestive Disorders: _____ |
| 2. Backaches: _____     | 6. Arthritis: _____    | 12. Nervousness: _____         |
| 3. Heart Trouble: _____ | 7. Headaches: _____    | 13. Sinus Trouble: _____       |
| 4. Diabetes: _____      | 8. Numbness: _____     | 14. Anemia: _____              |
|                         | 9. Asthma: _____       | 15. Rheumatic Fever: _____     |
|                         | 10. Neuritis: _____    | 16. Cancer: _____              |

What Medications or Drugs Are You Taking?: \_\_\_\_\_

ARE YOU INSURED? YES NO Company: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ Has your deductible been met? YES NO

Patient's Signature: \_\_\_\_\_ S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse:: \_\_\_\_\_ S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date: \_\_\_\_\_

Signature Authorizing Care:: \_\_\_\_\_ Date: \_\_\_\_\_

**IF YOU WERE INVOLVED IN A MOTOR VEHICLE OR WORK RELATED ACCIDENT  
PLEASE COMPLETE THE INFORMATION ON THE REVERSE SIDE**

**IF YOURS IS AN ACCIDENT RELATED INJURY PLEASE COMPLETE  
THE FOLLOWING QUESTIONS**

Date of Accident: \_\_\_\_\_ Hour: \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ Location: \_\_\_\_\_

Type of Accident:  Auto Accident  On The Job Injury  Slip & Fall  Other: \_\_\_\_\_

**If Not an AUTO ACCIDENT:**

Please Describe the Circumstances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did You Report The Injury To Your Foreman or Employer?  YES  NO Did They Recommended Care At Our Office  YES  NO

Name of Person Reported To: \_\_\_\_\_ Position: \_\_\_\_\_

**If AUTO ACCIDENT:**

Were you the  Driver  Front Seat Passenger  Back seat Passenger  Pedestrian  Other: \_\_\_\_\_

If Auto Collision: Where You Struck From  Behind  Right Side  Left Side  Front  Vehicle Was Parked

Did Your Car Strike The Other Vehicle(s) Involved?  YES  NO Or Did The Other Vehicle Strike Yours?  YES  NO, Undetermined

As a Result of the Accident Were Traffic Citations Issued To you  YES  NO To the Driver(s) of The Other Car(s)  YES  NO  
To the Driver of Your Car  YES  NO

Did You Require Post Accidental Hospitalization?  YES  NO Name of Hospital: \_\_\_\_\_

List the Extent of the Injuries As You Know Them: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Face Flushed    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems too Heavy   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pain & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes  | <input type="checkbox"/> Loss of smell   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pain & Needles in Legs | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Ears Ring           | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> _____         |

Symptoms Other Than Above: \_\_\_\_\_  
\_\_\_\_\_

Have You Lost Any Days of Work?  YES  NO Dates: \_\_\_\_\_

**INSURANCE COMPANY INFORMATION:**

My Company: \_\_\_\_\_

Company of Person Responsible for Injuries: \_\_\_\_\_

Have You Been Contacted By an Insurance Adjustor or Company Representative Regarding This Claim?  YES  NO

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient

Date

## **Identification of Persons with Authorization of Access to Patient Health Information**

Those individuals or parties that could have access to Patient Health Information at Loving Care Family Chiropractic Center include but may not be limited to:

The staff of Loving Care Family Chiropractic Center. This includes:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Necessary health care providers or vendors who may need to be consulted if related to the patient's condition. This includes:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

The minimum categories and or types of Patient Health Information necessary for access by these individuals or parties include but are not limited to:

**(Insert Health History Form, Insurance form, etc)**

# Loving Care Family Chiropractic

925 Main Street Suite 108 Stone Mountain, GA 30083  
678.476.3778 Office 770.938.7237 Fax

## Informed Consent to Medical and or Chiropractic Treatment and Care

INITIALS  
[ ] [ ]  
Doctor Patient

I have been informed that it is not uncommon for the patient to have some increased discomfort after and adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms I can call the clinic where I am being seen during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any test were performed outside of this office (laboratory, MRI or any other diagnostic procedures). I understand that the Doctor will notify me of the results at my next schedules appointment.

INITIALS  
[ ] [ ]  
Doctor Patient

I hereby request and consent to the performance of chiropractic and or medical adjustments, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor named bellow and/or in his clinic authorized by the doctor listed below. I have had an opportunity to discuss with the doctor listed bellow and/or other office or clinic personnel, the nature and purpose of the chiropractic and/or medical adjustment and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic and/or medical there are some very slight risk of treatment, including, but not limited to muscle strains and sprains, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor considers at the time, based upon the facts then known, is in my best interests.

INITIALS  
[ ] [ ]  
Doctor Patient

I have read the above consent, with the doctor as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

### TO BE COMPLETED BY PATIENT

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Please Print

Patient's Signature: \_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature