INFORMATION/APPLICATION FOR CARE

In order to better serve you, please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT)

Today's Date ________________________

Name _____________________________________ Home Phone __________________ Work Phone ___________________

Cell Phone _________________________ E-Mail Address ____

Address _______________________________________ City _______________________ State ________ Zip ____________

Age ______ Birth date ________________________ Marital Status: S M W D Age of Children __________________

Your Employer ________________________________ Occupation _______________________ Years On Job ____________

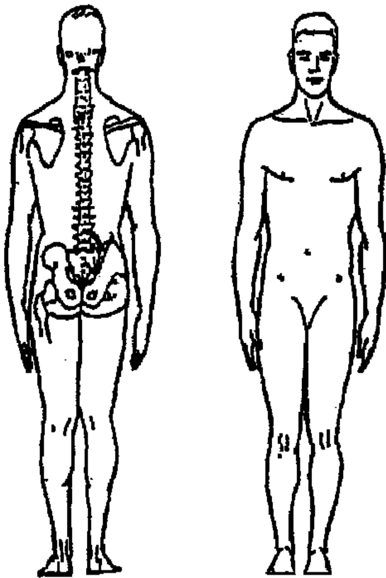
Employer Address __________________________________ City _______________________ State _______ Zip _________

Name of Spouse or Parent ____ Their Birth Date ___________________

Spouse Employer ______________________________ Occupation _______________________ Work Phone _____________

Employer Address ___________________________________ City ______________________ State ________ Zip ________

Referred to our office by: ____



COMPLETE THESE DIAGRAMS:

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain below.

PLEASE LIST MAJOR COMPLAINTS

____

____

____

____

Please List All Medications You Currently Take and Why?

____

____

____

Please circle any of the symptoms/conditions you have had in the past:

Headache	Arthritis	Sinus Problems
Neck Pain/Stiff	Fatigue	Dizziness
Mid Back Pain	Difficulty Sleeping	Ringing in Ears
Lower Back Pain	Depression	Digestive Problems
Numbness in Fingers	Heart Problems	Ulcers
Numbness in Toes	Stroke	Constipation/Diarrhea
Tingling in Arms	Blood Clots	Cancer ______________________
Tingling in Legs	High Blood Pressure	Vision Problems
Curvature of Spine	Lung or Breathing Problem	Kidney Problems
Bursitis	Allergies	Liver Problems
Foot / Knee Pain	Asthma	Seizures

Any Other Health Problems Not Covered Above:

____

____

**** If your condition is due to an accident, please fill out the Accidental Injury Information Sheet**

Insurance Company ______________________________________ Your Social Security # ___________________________

Policy holder's Name:______________________________ SS# ___________________________ Date of Birth ___________

Do you have Medicare? Yes ____ No ____

Do you have a secondary/supplemental insurance? Yes___ No___

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's/Guardian Signature ____ Date _________________________

Notice to our patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

In consideration of your undertaking to care for me, I agree to the following:

- You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.
- I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
- In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly to me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay you.
- In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Georgia.
- I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
- This Authorization and Assignment will be in continual effort until revoked by both parties.
- I agree that a photo copy shall serve as the original.

Patient's/Guardian Signature ____ Date _________________________