Back to Health Chiropractic

Dr. Robert Moore
801 Chickamauga Ave
Rossville, GA 30741
Phone: (706) 841-9969
Fax: (706) 841-7590

PATIENT INFORMATION

(First) (Middle) (Last)

Patient Name _____

Street Address_____

City_____ State_____ Zip_____

Cell Phone _____-_____-_____ Home Phone_____-_____-_____

E-mail _____ Social Security No._____-_____-_____

Date of Birth _____-_____-_____ Age _____

Sex _____Male _____Female Height _____ Weight _____

- ❑ Minor
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widowed

Have you ever been to a Chiropractor before? _____ If so, Dates_____

Whom may we thank for referring you? _____

Who is your Primary Care Physician? _____

Occupation _____ Employer _____

Employer Phone _____ Employer Fax _____

Spouse's Name

_____

Children's Names & Ages

_____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

INSURANCE

Primary Insurance _____

Name of Insured _____ Insured's S.S. No._____

Insured's Employer _____ Insured's Date of Birth _____

Secondary Insurance _____

Name of Insured _____ Insured's Date of Birth _____

PATIENT CONDITION

Primary Complaint _____

When did your primary symptoms appear?_____

Is this condition getting progressively worse? _____No _____Yes _____Unknown

How often do you have this pain?_____

Is it constant or does it come and go?_____

Type of pain:

- ❑ Sharp
- ❑ Throbbing
- ❑ Aching
- ❑ Burning
- ❑ Cramps
- ❑ Swelling
- ❑ Dull
- ❑ Numbness
- ❑ Shooting
- ❑ Tingling
- ❑ Stiffness
- ❑ Other_____

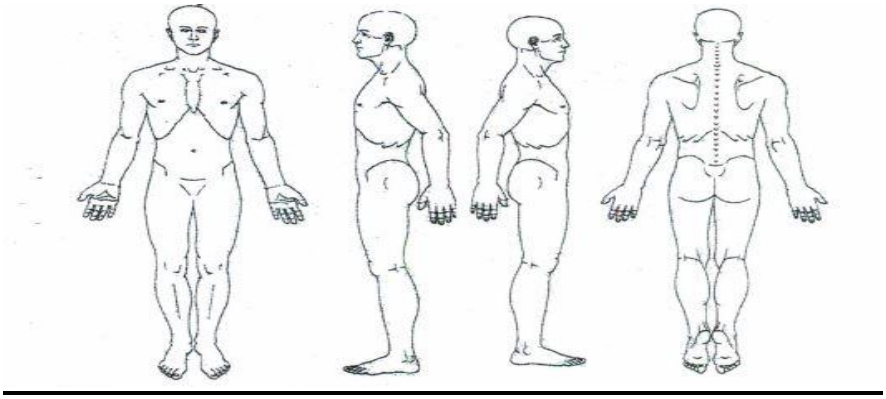
Activities or movements that are painful to perform:

- ❑ Sitting
- ❑ Walking
- ❑ Lying Down
- ❑ Standing
- ❑ Bending

Rate the pain on a scale from 0 (no pain) to 10 (severe pain):

0 1 2 3 4 5 6 7 8 9 10

On the drawings below, please **circle the areas of complaint:**



Secondary Complaint _____

ACCIDENT INFORMATION

Is the condition due to an accident? _____No _____Yes Date_____

Type of Accident

- ❑ Auto
- ❑ Home
- ❑ Work
- ❑ Other_____

If yes, please describe _____

To whom have you made a report of your accident?

- ❑ Auto Insurance
- ❑ Employer
- ❑ Work Compensation
- ❑ Other_____

HEALTH HISTORY

What treatment have you already received for your condition?

- ❑ Medications
- ❑ Surgery
- ❑ Physical Therapy
- ❑ Chiropractic Services
- ❑ None
- ❑ Other_____

Have you had spine, joint, or limb surgeries? _____

_____

_____

Please check all that apply to you

- ❑ Pacemaker
- ❑ Smoking
- ❑ Alcohol
- ❑ Recent Fever
- ❑ Diabetes
- ❑ Osteoporosis
- ❑ Epilepsy/Seizures
- ❑ Herniated Disc
- ❑ Morning Pain or Stiffness
- ❑ Pain Unrelieved by Position or Rest
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ Digestive Issues
- ❑ Hepatitis
- ❑ Headaches
- ❑ Menstrual Problems
- ❑ Urinary Problems
- ❑ Corticosteroid Use
- ❑ Pain at Night
- ❑ Visual Disturbances
- ❑ Dizziness or Fainting
- ❑ Thyroid Issues
- ❑ Abnormal Weight Loss
- ❑ Abnormal Weight Gain
- ❑ Other_____ _____ _____
- ❑ None
- ❑ Numbness
- ❑ Cancer or Tumor

Are you **pregnant**?

- ❑ No
- ❑ Yes Due Date_____

Exercise

- ❑ None
- ❑ Light
- ❑ Moderate
- ❑ Heavy

Allergies _____

Medications_____

_____

_____

_____

Vitamins/Supplements_____

_____

_____

Back to Health Chiropractic

Dr. Robert Moore

801 Chickamauga Ave
Rossville, GA 30741
Phone: (706) 841-9969
Fax: (706) 841-7590

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, modalities, and, if necessary, diagnostic X-rays on me (or on the patient, for whom I am legally responsible, named here:_____) by the chiropractic physician and /or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic and/ or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the chiropractic physician and/or with other office or clinic personnel the nature and purpose of the chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in best interests at the time, based upon the facts then known.

I have read, or have head read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient (or legal representative):

Print Patient's Name _____

Signature of Patient _____ Date _____

Print Name of Guardian _____

Signature of Guardian _____ Date_____

PATIENT HEALTH INFORMATION CONSENT FORM

Patient Name_____ Date of Birth _____

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 affect 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 have 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.
8. I give consent to allow this clinic to use my address, phone number, and/or e-mail to contact me with birthday cards or other health related information.

9. I understand that physical medicine modalities are provided in an open setting. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor or another staff member in private, I may request a room for those conversations.

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

Patient's Signature _____ Date _____

Back to Health Chiropractic

Dr. Robert Moore
801 Chickamauga Ave
Rossville, GA 30741
Phone: (706) 841-9969
Fax: (706) 841-7590

FINANCIAL AGREEMENT

We welcome you to our office and assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, please read the following regarding how your medical bills will be handled.

Payment is expected at the time services are rendered unless other arrangements are made in advance.

If you have insurance coverage, in signing this financial agreement, you agree to assign directly to our physicians all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The physician may use my health care information and may disclose such information with my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services.

I have read and agree with the above. I further agree that if this account has to be placed in the hands of an attorney or collection agency for collections, I will be responsible for all reasonable attorney's fees and court costs.

Patient's Signature _____ Date _____

PATIENT COMMUNICATION CONSENT FORM
TEXT/EMAIL MESSAGE ALERTS

I authorize Back to Health Chiropractic to send text message and/or email appointment reminders to me on my provided cell phone number and/or email address. I understand that I may receive account information such as future appointments, office location and missed appointment notifications.

Cell Phone _____

Email _____

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the account(s), that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text and email messaging services. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply.

Signature _____ Date _____

It is important to note that text and email communication is not always secure. Text and email messages can be intercepted and for this reason, we do not communicate personal health information through this method.