New Patient Form

Please print clearly

Today's Date:_______________

Name:____
Last First MI

Preferred name to be called:_____________________ Email:________________________________

Address:____
Street City State Zip

DOB:_______________________ Age:______ Sex:____________ SSN#: __ __ __ - __ __ - __ __ __ __

☑ *Please check a box for the preferred # to call to confirm or reschedule appointments:*

Home#_______________________ Cell#_______________________ Work#_______________________

Occupation: _________________________________ Employer: _________________________________

Emergency Contact:____________________ Relationship:__________________Phone#:___________________

Chief Complaint:

1. Please describe onset.
   ____
   ____
2. Please describe current symptoms.
   ____
   ____
3. Any previous treatment by another physician for this problem?
   ____
   ____
4. Any previous accidents or other athletic injuries?
   ____
   ____

Request for Payment of Benefits to Provider of Care:

I herby authorize the _______________________________ Insurance Company/ Insurance Administrator to pay by check, and for it to be mailed directly to: Georgia Sports Chiropractic 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 Signature Date

New Patient Form

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How did you hear about us?:____________________________ Name of Referral:__________________________

Have you seen a Chiropractor before?____ Was it this year?_____ How many times?______________________

Name of Previous Chiropractor:

____

Medicines/Allergies:

What medications are you currently taking? (Drug name, dose, and times per day) Not taking medication, write N/A.

____

____

____

Social History

Smoker: Yes ___ No___ If yes, how many packs per week: _____________

Alcohol: Yes ___ No___ If yes, how many drinks per week: _____________

Past Medical History

1. Medical Problems (Current or past) Not including your current injury:

____

____

____

____

2. Prior surgeries:

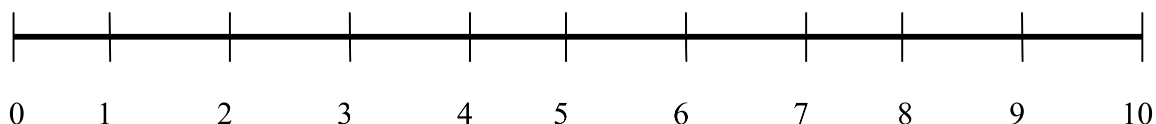
____

____

____

Numerical Rating Scale:

Please place a mark on the line that corresponds to your *current* pain level:



0 1 2 3 4 5 6 7 8 9 10

No pain! *Worse pain ever!*

Georgia Sports Chiropractic

Athletic Injury Profile

Please print clearly

What types of sports are you involved in?

1. Major Sports: ____

2. How Many Years: ____

   (Only for **Student Athletes**) School: ______________________________

   Running Club or Track Club: ______________________

3. Cross Training:____

4. Are you part of a gym? ______________________ Cross Fit?______________

5. Average weekly distance or duration:

   Running: ____________ Cycling: ______________ Swimming: ____________

6. Current weekly distance or duration:

   Running: ____________ Cycling: ______________ Swimming: ____________

7. Shoes? Brand:______________ (Ex. Nike) Style :______________ (Ex. Pegasus) Type:________________ (Neutral or stability)

8. Do you wear orthotics? Yes______ No______

   If so, who prescribed and made the orthotics? ______________________________

9. Are you training for specific goals in mind? (E.g. 10k, Marathon, Ironman, etc.)

   ____
   ____
   ____

10. Do you stretch? Yes_____ No____ If yes, how and when?

    ____
    ____
    ____

11. Do you ice or use any system of home rehab/strengthening?

    ____
    ____
    ____

754 Peachtree St, N.E. • Suite 105, Atlanta, GA • (404) 872-4878 • Fax:(404) 872-4878

Georgia Sports Chiropractic

Informed Consent for Treatment

Please print clearly

I, ______________________________________, do hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

Although spinal manipulation /adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associates with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Also, I am aware the possibility of bruising and soreness with soft tissue therapy. Bruising and soreness are temporary.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to the aforementioned. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. 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 condition(s) for which I seek treatment.

Patient Signature:_____________________________________ Date:________________

Georgia Sports Chiropractic

Informed Consent for Treatment

Please print clearly

Consent for Use or Disclosure of Health Information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we will always respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent form (Article 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us anytime for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding to us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

______________________________	______________________________
Printed Name	Authorized Provider Representative
______________________________	______________________________
Signature	Date

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