ADVANCED
Chiropractic Center

Today's Date:_____

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:___Zip:_____

Email: _____@_____

Home Phone:_____Work Phone: _____Cell :_____

Social Security #:_____ Age:_____ □ Male □ Female

Marital Status: □ Married □Single □Divorced □Separated □Other _____

Name of Spouse or Nearest Relative:_____Phone:_____

Your Occupation_____ Your Employer:_____

Referred to this Office by: □Friend/Family Member - Name?_____

□Yellow Pages □ Mail □Clinic Location □Other_____

Payment for Services will be by: □Cash □Check □Credit Card □Health Insurance

□Automobile Insurance □Worker's Compensation

Name of Insurance Co.:_____Insured's Employer: _____

Insured's Social Security #:_____ Insured's Date of Birth:_____

Are you covered by more than one insurance company? □Yes □No Name_____

Preston Peacock DC DABCO
408 SW HWY 80
Pooler GA, 31322
Phone 912-748-0350
Fax 912-450-0350
Email: AdvancedChiro912@gmail.com

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No

Have you been treated by a chiropractor before? ☐Yes ☐No

If so, has it been in the last 6 months? ☐Yes ☐No

Describe Condition_____Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Have you ever had a metal implant: ☐Yes ☐No **Have you ever had a gunshot:** ☐Yes ☐No

ACCIDENT HISTORY

☐Job ☐Auto ☐Other 1. _____Date:_____

☐Job ☐Auto ☐Other 2._____Date:_____

(If more, please turn over)

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PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1._____ _____
Major Complaint — Pain Level: 1-10, with 1 being least serious

2._____ _____
Major Complaint — Pain Level: 1-10, with 1 being least serious

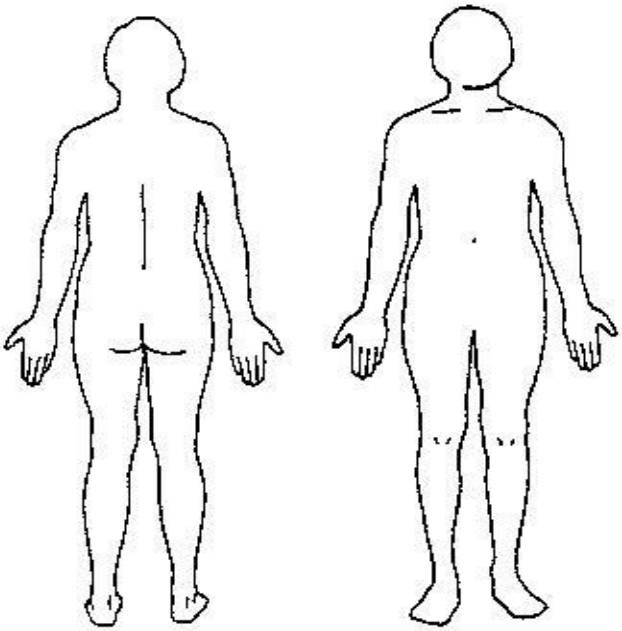
3._____ _____
Major Complaint — Pain Level: 1-10, with 1 being least serious

4._____ _____
Major Complaint — Pain Level: 1-10, with 1 being least serious

RATE YOUR PAIN

Place an "X" on the drawings where you have pain and indicate the type of pain you are experiencing:

A=Ache
B=Burning
N=Numbness
P=Pins and Needles
ST=Stabbing
SP=Spasm
T=Throbbing



Additional notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pain Scale

Please circle the number that best describes your **OVERALL** pain:

0 1 2 3 4 5 6 7 8 9 10 10+

None Little Moderate Severe Excruciating

Major Complaints Continued…

SYMPTOMS ARE WORSE IN: ☐MORNING ☐AFTERNOON ☐NIGHT

WHEN AND HOW OCCURRED:_____

_____

SYMPTOMS DEVELOPED FROM:

☐JOB RELATED INJURY ☐AUTO ACCIDENT ☐OTHER ☐ACCIDENT ☐ILLNESS

☐UNKNOWN CAUSE ☐GRADUAL ONSET DATE OCCURRED:_____

SYMPTOMS HAVE PERSISTED FOR # _____HOUR(S) _____DAY(S) ____WEEK(S) ____MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ☐COME & GO ☐ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐NO ☐YES **WHEN**:_____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS:

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS: ☐NO ☐YES WHAT KIND?_____

ARE YOU TAKING ANY MEDICATIONS: ☐NO ☐YES WHAT KIND?_____

ARE YOU PREGNANT ☐NO ☐YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT *AGGRAVATE* YOUR CONDITION:

☐BENDING ☐REACHING ☐STRAINING AT STOOL ☐COUGHING ☐SITTING ☐TURNING HEAD
☐LIFTING ☐SNEEZING ☐WALKING ☐LYING DOWN ☐STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT *RELIEVE* YOUR CONDITION:

☐BENDING ☐SITTING ☐LIFTING ☐STANDING ☐LYING DOWN ☐TURNING HEAD
☐REACHING ☐WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

☐blurred vision	☐buzzing in ears	☐cold feet	☐cold sweats	☐cold hands
☐concentration loss/confusion	☐constipation	☐depression/weeping spells	☐diarrhea	☐dizziness
☐face flushed	☐fainting	☐fatigue	☐fever	☐head seems too heavy
☐headaches	☐insomnia	☐light bothers eyes		☐loss of balance
☐loss of smell	☐loss of taste	☐low resistance to colds		☐muscle jerking
☐numbness in fingers	☐numbness in toes	☐pins and needles in arms		☐pins and needles in legs
☐ringing in ears	☐shortness of breath	☐stiff neck		☐stomach upset

_____

Patient's Signature Date

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The following is a statement of our financial policy. We require you to sign and read this document prior to treatment by this facility.

Patients without Insurance:
We request that 100% of the first visit be paid at the time of service. We do offer a time of service discount for follow-up visits. We are happy to accept your cash/check, MasterCard, Visa or Discover Credit Card.

Initial_____

Group or Individual Insurance:
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are **not a guarantee of payment.** As a courtesy to you, our office will file your claim with your insurance carrier. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, co pays or deductibles. It is the patient's responsibility to understand their insurance coverage.

Initial _____

Patient Responsibility
When you receive a statement from our office you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, please contact our office. Do not ignore the bill as it may result in turning the balance over to an outside collection agency.

I understand that I am financially responsible to Advanced Chiropractic Center for any balance not covered by the insurance carrier.

Initial _____

Assignment of Benefits
I authorize this office to release any medical information relating to my treatment to any insurance companies, which may be responsible for paying benefits to me. I hereby assign and authorize my insurance benefits to be paid directly to Advanced Chiropractic Center.

_____
Patient name (please print)

_____
Patient or Responsible Party's Signature Date

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMAITON TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Advanced Chiropractic Center has the right to use and/or disclose information about me (or someone else for whom I have the authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations. I understand they will not release any record without written authorization by me or persons elected.

The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which is has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient.

The Practice may communicate confidential information to me, including invoices for services, e-mail, and call for appointment times or missed appointments, birthday cards and Holiday cards.

I also realize that I may be overheard or may hear other patients talking while in the therapy bay.

Authorizing Patient Name (Please Print)

Signature Date

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Informed Consent

Patient Name:_____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. The procedure is referred to as spinal manipulation or spinal adjustment. As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains, and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-rays equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

_____ _____

Date Printed Name

_____

Signature or Signature of Guardian or Parent

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CREDIT GUARANTEE
INSURANCE ASSIGNMENT

INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

FILING PROCEDURE

Claims for initial services are submitted within 5 days after your first visit.

If the bill has not been paid by your insurance company within 3 months, we will contact you to discuss the issue. If the issue cannot be resolved with your insurance company, the liability will then fall to you and we will make 3 attempts to collect the payment with you. If no payment can be collected, we will then charge your credit card.

PERSONAL BALANCES

Estimated personal portions are paid at the time of service unless you prefer to pay weekly. Weekly payments also require this credit card guarantee, and any personal balance not paid by Friday will also be automatically charged to your designated card below.

CREDIT CARD: (circle one) VISA MC DISCOVER

CARDHOLDER NAME: _____

CARD #_____ EXP. DATE:_____

CSC # (3 digits on back of card): _____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 90 days after submission of my claim, or should I terminate care before being dismissed by your physician, I will be charged the amount due.

_____

SIGNATURE DATE