Georgia Spine and Sports Rehab
Dr. Joseph A. Krzemien

WELCOME TO OUR OFFICE
PATIENT INFORMATION FORM

NAME _____ DATE OF BIRTH _____ AGE ____ SEX ☐ M ☐ F

ADDRESS _____ CITY _____ STATE____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SOCIAL SECURITY NUMBER _____ EMAIL ADDRESS _____

Check One ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated Name of Spouse: _____

PREFERED METHOD OF CONTACT: ☐ HOME PHONE ☐ CELL PHONE ☐ WORK PHONE ☐ EMAIL

MAY WE LEAVE A MESSAGE REGARDING YOUR HEALTHCARE AND/OR APPOINTMENT? ☐ YES ☐ NO

EMPLOYER _____ POSITION _____

EMPLOYER ADDRESS _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ CONTACT #_____

IF PATIENT IS A MINOR DO YOU AUTHORIZE GEORGIA SPINE AND SPORTS REHAB TO TREAT SAID MINOR WITHOUT A PARENT/GUARDIAN PRESENT FOR FUTURE APPOINTMENTS? **SIGNATURE:** _____

WHAT SCHOOL DO YOU ATTEND?_____

COMPLETE THE FOLLOWING SECTION IF SOMEONE OTHER THAN PATIENT IS FINANCIALLY RESPONSIBLE:

RESPONSIBLE PARTY_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL_____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____

EMPLOYER_____ POSITION_____

Who is Responsible for Your Bill, You and ☐ Spouse ☐ Health Insurance ☐ Auto Insurance ☐ Workman's Comp ☐ Attorney

Personal Health Insurance (Name) _____ Policy ID _____ Group #_____

PLEASE GIVE YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE TO THE RECEPTIONIST FOR INSURANCE BILLING PURPOSES

I HEREBY GIVE CONSENT FOR THE ABOVE NAMED DOCTORS TO TREAT ME. THIS MAY OR MAY NOT INCLUDE THE NEED FOR X-RAYS. IF X-RAYS ARE NEEDED I WILL BE INFORMED BY THE DOCTOR FIRST. I AGREE TO ACCEPT FINANCIAL RESPONSIBILITY FOR ANY CHARGES INCURRED. I ALSO HEREBY ASSIGN TO THE ABOVE NAMED DOCTORS ALL BENEFIT PAYMENTS PROVIDED BY MY HEALTH INSURANCE COMPANY, AUTO INSURANCE COMPANY OR A SETTLEMENT FROM MY ATTORNEY FOR SERVICES DESCRIBED. I GIVE GEORGIA SPINE AND SPORTS REHAB PERMISSION TO TREAT ME IN AN OPEN ROOM WITH OTHER PATIENTS. I AM AWARE OTHER PERSONS MAY OVERHEAR SOME OF MY HEALTH INFORMATION. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM OR PENDING LEGAL CASE. I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF GEORGIA SPINE AND SPORTS REHAB'S FINANCIAL AND HIPAA POLICY.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY_____ **DATE**_____

MEDICAL/SURGICAL HISTORY:

Purpose of This Appointment: _____

Have you received chiropractic care before? ☐ YES ☐ NO

Other Doctors Seen For This Condition: ☐ YES ☐ NO Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ YES ☐ NO

Is This Condition ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date and Time of Accident _____ Have you made a report of your accident to your employer? ☐ Yes ☐ No

Major accidents or falls in the past? _____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL

☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever

☐ Forgetfulness
☐ Headache
☐ Loss of Sleep
☐ Loss of Weight
☐ Nervousness
☐ Numbness
☐ Sweats

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

GENITO-URINARY

☐ Blood in Urine
☐ Frequent Urination
☐ Lack of bladder control
☐ Painful Urination

GASTRO-INTESTINAL

☐ Appetite Poor
☐ Bloating
☐ Bowel Changes
☐ Constipation
☐ Diarrhea

☐ Excessive Hunger
☐ Excessive Thirst
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal Bleeding
☐ Stomach Pain
☐ Vomiting

☐ Vomiting Blood

CARDIO-VASCULAR

☐ Chest Pain
☐ High Blood Pressure
☐ Irregular Heart Beat
☐ Low Blood Pressure

☐ Poor Circulation
☐ Rapid Heart Beat
☐ Swelling of Ankles
☐ Varicose Veins
☐ History of Blood Clotting

EYE, EAR, NOSE, THROAT

☐ Bleeding Gums
☐ Blurred Vision
☐ Crossed Eyes
☐ Difficulty Swallowing
☐ Double Vision

☐ Earache
☐ Ear Discharge
☐ Hay Fever
☐ Hoarseness
☐ Loss of Hearing
☐ Nosebleeds
☐ Persistent Cough
☐ Ringing in Ears

☐ Sinus Problems

☐ Vision-Flashes
☐ Vision-Halos

SKIN

☐ Bruise easily
☐ Hives

☐ Itching
☐ Change in Moles
☐ Rash
☐ Scars

☐ Sore that won't heal

MEN only

☐ Breast Lump
☐ Erection Difficulties
☐ Lump in Testicles
☐ Penis Discharge
☐ Sore on Penis
☐ Other: _____

WOMEN only

☐ Abnormal Pap Smear
☐ Bleeding between Periods
☐ Breast Lump
☐ Extreme Menstrual Pain
☐ Hot Flashes
☐ Nipple Discharge

☐ Painful Intercourse

☐ Vaginal Discharge
☐ Other: _____

Date of last Menstrual Period:

Have you had a mammogram?
☐ YES ☐ NO

Are you currently pregnant?
☐ YES ☐ NO

Do you take oral contraceptives?
☐ YES ☐ NO

Number of Children:

PLEASE TURN PAGE OVER TO COMPLETE FORM

CONDITIONS Check (√) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

HOSPITALIZATIONS: (Women- Include Pregnancy History)

YEAR	HOSPITAL	REASON/OUTCOME

LIST ANY KNOWN ALLERGIES:

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

GEORGIA SPINE & SPORTS Rehab

FINANCIAL POLICY

1. STATEMENTS ARE MAILED OUT EACH MONTH. PAYMENTS ARE DUE 28 DAYS AFTER THE STATEMENT DATE UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.

2. ACCOUNTS THAT HAVE NOT RECEIVED ANY PAYMENTS FOR 3 MONTHS WILL BE REFERRED TO A COLLECTION AGENCY. ADDITIONALLY, A 40% COLLECTION FEE MAY BE ASSESSED ON THE BALANCE.

3. CO-PAYS/ CO-INSURANCE ARE DUE AT THE TIME OF SERVICE.

4. PATIENT MEDICAL RECORDS ARE THE PROPERTY OF GEORGIA SPINE AND SPORTS REHAB. ANY PATIENT REQUESTING A COPY OF THEIR MEDICAL RECORD WILL BE CHARGED A FEE THAT FOLLOWS THE GUIDELINES SET BY GEORGIA STATE MANDATE.

5. ALL PATIENTS ARE RESPONSIBLE TO KNOW AND MONITOR THEIR INSURANCE BENEFITS. IMPORTANT THINGS TO PAY ATTENTION TO ARE CO-PAYS, DEDUCTIBLES, REFERRALS, NUMBER OF VISITS, NON-COVERED SERVICES, AND WHETHER THE DOCTOR IS IN-NETWORK WITH YOUR PLAN.

6. WE WILL BILL YOUR INSURANCE FOR YOU, AND WE ALLOW THE INSURANCE COMPANY 60 DAYS TO PAY US. IF THEY HAVE NOT PAID AFTER 60 DAYS, THE BALANCE WILL BECOME YOUR RESPONSIBILITY, AND YOU CAN FOLLOW UP WITH YOUR INSURANCE COMPANY FOR REIMBURSEMENT. PLEASE INFORM US IF YOUR INSURANCE HAS CHANGED TO PREVENT PAYMENT DELAYS.

7. ALL INSUFFICIENT FUND CHECKS WILL BE CHARGED A $25.00 FEE.

8. APPOINTMENT CANCELATION FEE IS $45.00 FOR ALL APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE.

9. ALL FINANCIAL ACCOUNT QUESTIONS SHOULD BE DISCUSSED WITH THE OFFICE MANAGER.

I understand the above stated financial policy of Georgia Spine and Sports Rehab. I have been given an opportunity to have all my questions answered regarding these policies. I agree to accept financial responsibility for any charges incurred.

Patient/Guarantor Signature: _____ Date: _____

Staff: _____