CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

Confidential Patient Information (Please Print)

Today's Date ___/____/_____

Name _____ Home# ( ) _____ Cell# ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ DOB ___/___/_____ Marital Status: Single/ Married/ Widow/ Divorce Number of Children _____

Employer _____ Occupation _____ Years on Job _____

Employer's Address _____ City _____ State _____ Zip _____

Office Phone ( ) _____ SSN# _____- _____-_____ DL# _____

Do you have health insurance through your employer? ___yes ___no
Insurance Company _____ Member ID# _____

Name of Spouse/Parent/Guardian _____ DOB __/___/____
Spouse/Parent/Guardian Employer _____ Occupation _____ Years on Job ___
Employer's Address _____ City _____ State _____ Zip _____

Does your Spouse/Parent/Guardian have health insurance through employment: ___yes ___no
Insurance Company _____ Member ID# _____

Describe the MAJOR COMPLAINT that bring you to our office today?

_____

Is your condition due to an accident? ___yes ___no **Date of accident _____/_____/_____**
Type of accident □ Auto □ Work □ at Home □ Other _____

Have you ever been in an auto accident? □ Past Year □ Past 5 years □ Over 5 years □ Never

Date ____/____/_____

How did you hear about our office? □ Internet □ Insurance □ Passing by □ Referral _____

□ Friend_____ □ Other

I/we agree to pay for services rendered to the above mentioned patient as the charges are incurred. I understand and agree that health and 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 non covered. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered me will become immediately due. Full payments for services are due at the end of each visit. If for some reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Patients Signature _____ Date _____/_____/_____

Parent/Guardian Signature _____ Date _____/_____/_____

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

What activities aggravate this condition?

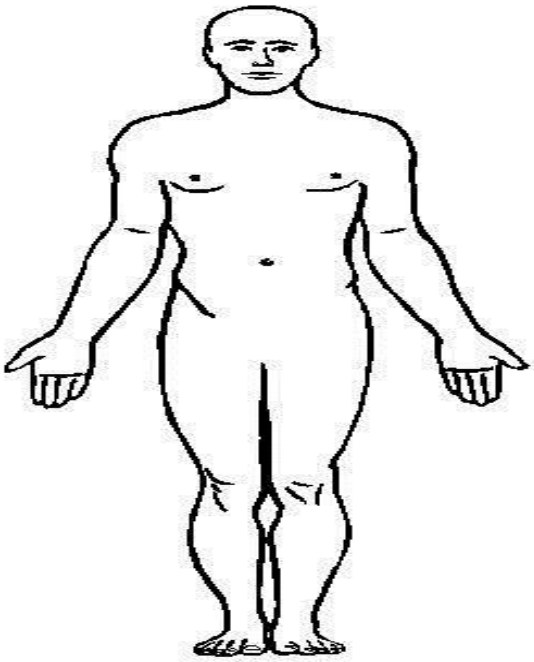
□ Standing	□ Lying on back	□ Bending forward
□ Walking	□ Lying face down	□ Bending backward
□ Sitting	□ Reaching over head	□ Squatting
□ Lifting	□ Reaching behind	□ Pulling
□ Sneezing	□ Reaching in front of body	□ Pushing
□ Coughing	□ Bending to the right	□ Bending to left

What makes it better? _____

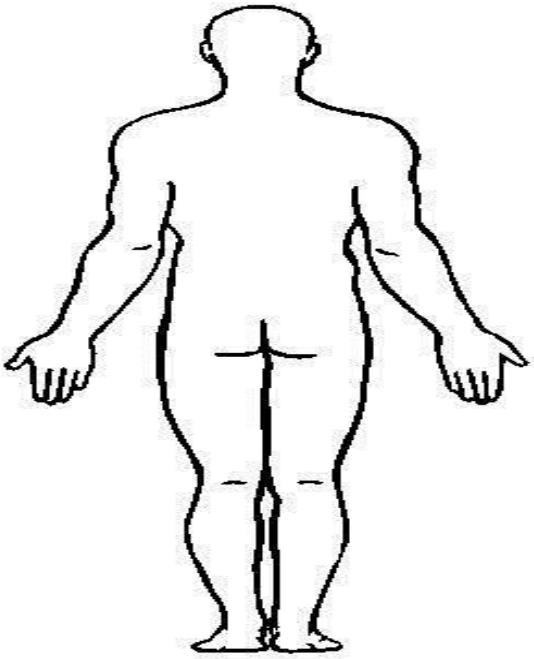
DATE OF ANY PREVIOUS SPINAL X-RAY FILMS _____

PLEASE COLOR IN THE AREA OF YOUR CONCERN.

R Front L



L Back R



6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

AUTHORIZATIONS AND CONSENTS

Consent for Treatment

- I, the undersigned, hereby authorize Dr. Tiffany Ringfield, of Cornerstone Chiropractic of Lithia Springs, and whomever we may designate as assistant to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary on me (or on the patient named below for whom I have a legal responsibilities).
- I understand and have been informed, that as in the practice of traditional medicine, the practice of Chiropractic involves some risk to treat, including but not limited to fractures, disc, injuries, strokes dislocations and sprains. I do not expect the doctor to anticipate and explain all risk and complications and I wish to rely upon the facts then known to him or her is in my best interest.
- I will give **Corner Chiropractic of Lithia Springs** permission to treat or instruct me in an open room where other protected health information during the course of care. Should I need to speak with the doctor at any time in private, I will notify the doctor and a room will be provided for these conversations.
- I, also, recognize that no guarantee or assurance has been made as to the results that maybe obtain during the course of treatment.

Financial Agreement

- I understand that agreements with health or accident insurance policies and attorney representation are arrangements between me and the above mention entities of this sentence. Upon request of me, this office will prepare any necessary health records, forms and reports to assist me in making collection form the insurance companies and/or attorneys and law firms and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittance for the conveyance of credit to my account.
- **I CLEARLY UNDERSTAND AND AGREE HOWEVER, THAT ALL SERVICES RENDERED TO ME WILL BE DIRECTLY CHARGED TO ME AND I WILL BE PERSONALLY RESPONSIBLE FOR PAYMENT**.
- I will be responsible for paying all professional charges not covered by insurance and/or attorney efforts. I will also be responsible for the cost any attorney and collection fees necessary for collection on my account(s).
- I will hereby authorize my Insurance Company/Administrator or Attorney/law firm to pay by check and be mailed directly to **Dr. Tiffany Ringfield of Cornerstone Chiropractic of Lithia Springs** for the expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional health services rendered.
- I will agree that this office be given power of attorney to sign or endorse my name on any draft for payment of my bill.
- There will be a $30 NSF fee for all returned checks and legal tender plus the amount of the service applied to your account that is due prior to your next appointment.

Authorization to Release Medical information

- I authorize the release of any medical information necessary to process my insurance claims and also certify that all insurance information given to this clinic is correct and complete.
- ***Initials_____ DATE_____/_____/_____***

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

Retirement/Destruction of X-Rays

- I hereby authorize **Cornerstone Chiropractic of Lithia Springs** or any of its designated surrogates to follow the rules of the GA Board of Chiropractic Examiners to retain original x-ray film or accurate copies for not less than three (3) years from the date of x-ray exposure; and all other patient records pertaining to my case including radiological diagnosis and clinical impressions shall be retained for not less than (7) years from the date of the last examination or treatment sessions.

Acknowledgement of Receipt of Notices for Privacy Practices

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I have read, or have had this two page document of consents and authorizations read to me. I have also had an opportunity to ask questions and discuss with the doctor of chiropractic and/or with the office personnel about the above authorizations and consents as well as the nature and purpose of Chiropractic adjustments and other procedures. By signing below, I agree to the above named procedures and consents. I intend for this authorization and consent form to cover the entire course of my treatment for my present condition and any future conditions for which I may seek treatment.

_____ _____
Printed Name of Patient Patients Signature

_____ _____
Printed named of Guardian or Parent Parent or Guardian's Signature

_____/_____/_____
Date Signed

Initials_____ DATE_____/_____/_____

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

HEALTH REVIEW – *PLEASE □ CHECK FOR PRESENT SYMPTOMS*

Skin Hair Nails
□Eczema
□Dry Scalp
□Oily Scalp
□Rough scaly scalp
□Yellow skin
□Bruise easily
□Paper thin nails

Eyes
□Blurred vision
□Double vision
□Excessive tearing
□Lack of tearing
□Light bothers eyes
□Excessive itching
□Painful in eyeball
□Eyes fatigue easily

Ears

□Loss of hearing
□Pain in ears
□Discharge from ears
□Vertigo
□Ringing in ears
□Nail biting
□Baldness

Nose Nasopharynx Sinuses
□Unusual nasal discharge
□Nose bleeds
□Pressure over eyes
□Pressure under eyes
□ Obstruction of nose
□ Frequent colds
□Sinusitis
□Nasal allergies
□Head feels heavy
□Loss of sense of smell
□Abnormal pain
□Any trauma to nose

Respiratory
□ Shortness of Breath
□ Can't Breath while lying down
□Dry Cough
□Productive Cough
□Coughing up blood
□Wheezing

Gastrointestinal
□Poor Appetite
□Constant Nibbling
□Difficulty in Swallowing
□Indigestion
□Can't eat some food
□Nausea & Vomiting
□Jaundice
□Abdominal pain
□Change of bowel habits
□Diarrhea
□Constipation
□Hemorrhoids

Genitourinary
urination is
□Frequent
□Normal
□Infrequent
the amount is
□High
□Normal
□Low
□Need to get up at night to urinate
□Abnormal intense desire to urinate
□Difficulty staring urination
□Decreased Output
□Pain on urination
□Dribbling
□Blood in urine
□Cloudy urine
□Lack of bladder control

Women Only
□Painful Period
□Spotting
□Vaginal Discharge
□Premenstrual Symptoms
□Irregular Periods
□Lumps in Breast
Pregnancies_____
Deliveries_____

Social History
□Smoking (#cigs_____)
□Other Tobacco Use
□Alcohol Use(amount_____)
□Drink Coffee or Tea (amount ____)
diet is
□balanced
□unbalanced
rest is
□Sufficient
□Insufficient
recreation is
□Sufficient
□Insufficient
my family stress
□Severe
□Moderate
□Minimal
□None
how do you like your work?
□I like it very much
□It's ok
□I hate it
my job stress is
□Severe
□Moderate
□Minimal
□None
□Nervousness
□Irritability
□Fatigue
□Depression
□Generally feel run-down
□Crave sweets
□Crave salt

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

Cardiovascular
□General Swelling
□Swelling in legs
□Swelling in face
□Swelling around eyes
□Chest pain
□Pounding heart beat
□Heart "jumps"
□Rapid heartbeat
□Blue or purple nail beds
□Fainting
□Hypertension

Vertebrobasilar
□Double vision
□Loss of coordination

Head
□Unusually frequent headaches
□Unusually severe headaches
□Head feel heavy
□Vertigo
□Light-headedness
□Loss of smell
□Loss of taste
□Loss of balance
□Dizziness

Neck
□Pain in neck
□Neck in pain with movement
□Swelling in neck
□Stiff neck
□Pinched nerve in neck
□Neck feels out of place
□Muscle spasms in neck
□Grinding sounds in neck
□Popping sounds in neck
□Limited neck movement

Shoulders
□Pain in shoulder (R-L)
□Irregular muscle movement
□Ringing in ear

□Heart Attack
□High Blood Pressure
□Irregular heart beat
□Hardening of the arteries
□Area of muscle weakness
□Dizziness with nausea
□Blurred vision
□Fainting spells
□Stroke
□Diabetes
□Pain over the heart
□Pain in hands
□Cold hands and/or feet
□Area of numbness
□Arthritis
□Previous neck or head injury
□Loss of memory
□Swollen joints in fingers
□Sore Joints in fingers
□Loss of grip strength
□Inability to form words (talk plainly)
□Periods of blindness in one eye
□Areas of abnormal sensations such as burning etc.
□Areas of Numbness
□Blood Vessel Disease (Phlebitis etc.)
□Check if you smoke
□Any of your family members have had any strokes

Mid Back
□Mid back pain
□Pain between shoulder blades
□Sharp stabbing pain
□Dull ache
□Pain from front to back
□Pain over kidney area
□Muscle spasms in mid back

Low Back
□Low back pain
□Low back feels out of place
□Low back muscle spasms

Hips, Legs & Feet
□Pain in buttocks
□Pain down leg
□Knee pain
□Leg cramps
□Pins & needles in legs
□Numbness in legs
□Numbness in toes
□Cold feet
□Swollen ankles
□Swollen feet

Mouth and Throat
□Pain in teeth
□Pain in throat
□Bleeding gums
□Cavities
□Abscessed teeth
□Dentures

Venereal Disease
□AIDS
□Syphilis
□Gonorrhea
□*other*

Please list any other problems or conditions
_____
_____
_____
_____
_____
_____

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

HEALTH QUESTIONNAIRE

Name: _____ Date: _____

List *all* of your current health problems: _____
_____
_____

List any other doctors seen and list treatment received and results obtained: _____
_____
_____

List all surgeries you have had and list dates: _____
_____
_____

List any medications you are now taking: _____
_____
_____

Have you ever been in an automobile accident? ___yes ___no If yes, indicate when _____

Have you ever been in an auto accident? __yes __no If yes, indicate when _____

Have you ever been in an industrial or any other injury for which you received treatment? __yes __no If yes, indicate when
_____
_____

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138

CORNERSTONE CHIROPRACTIC
of Lithia Springs 770-739-8118

Let Chiropractic be the Cornerstone of your Health

6949 S. Sweetwater Rd. ∞ Lithia Springs, GA 30122
Fax 866-699-7138