Dr. Matthew Germain
Dr. Steven Woltin
Dr. Crystal Andrews

Fax: 770.558.6783
Phone: 770.558.6580
www.lovethespine.com

Back to Balance Chiropractic Wellness Center

New Patient Intake

Title: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss (check one) Date: _____/_____/_____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Date of Birth: _____/_____/_____ Age: _____

Email: _____ Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Other_____ Gender: ☐Male ☐Female

Whom may we thank for referring you to us? _____

Preferred Language: (check one) □ English □ Spanish □ I choose not to specify □ Other _____

Patient Employer Data:

Employer Name: _____

Address Line: _____ City: _____ State: _____

Job Title / Position: _____ Description: _____

Emergency Contact Name: _____ Phone: (_____) _____-_____

Primary Doctor: _____ City: _____ State:_____

X-RAY Confirmation
This is to confirm that this office has advised me that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____
Signature Date

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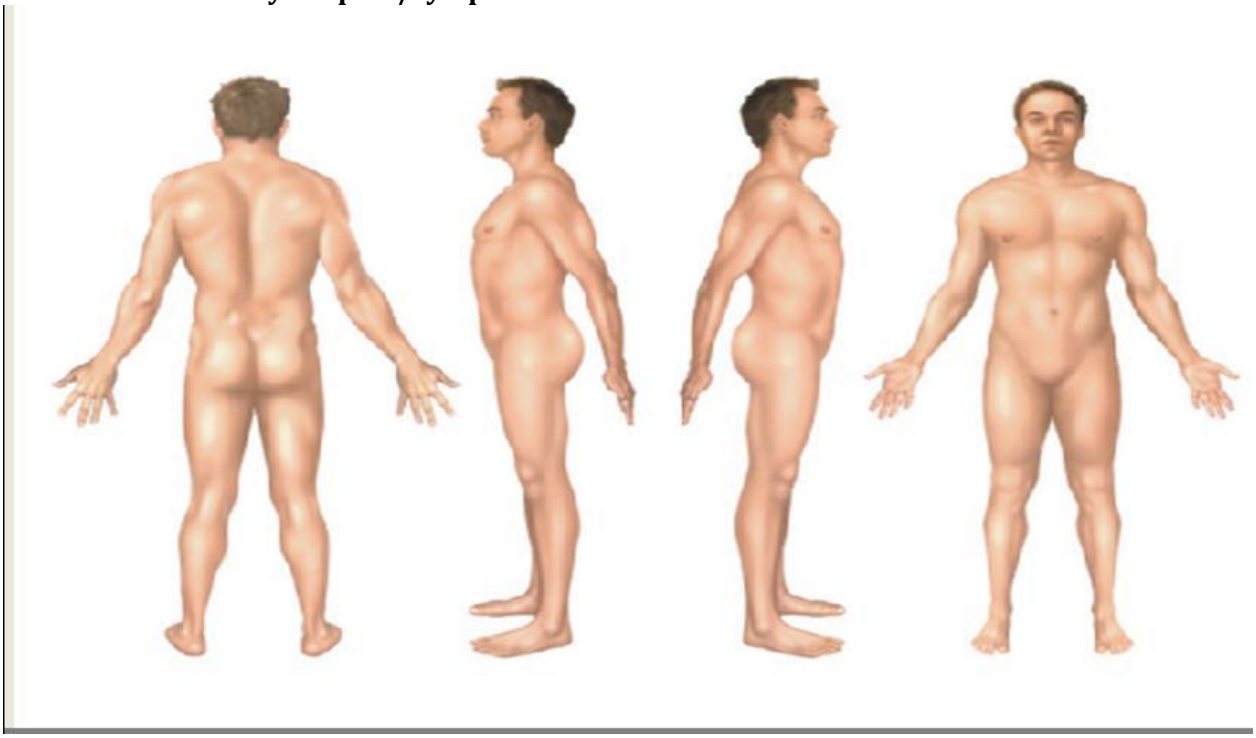
Please mark where your pain/symptoms are:



Please grade your pain on a scale of 0-10: Choose how frequent the pain is present:

[0= No Pain, 10= Extreme Pain]

Neck: 0 1 2 3 4 5 6 7 8 9 10 Seldom - Intermittent - Frequent - Constant

Upper Back: 0 1 2 3 4 5 6 7 8 9 10 Seldom - Intermittent - Frequent - Constant

Lower Back: 0 1 2 3 4 5 6 7 8 9 10 Seldom - Intermittent - Frequent - Constant

_____: 0 1 2 3 4 5 6 7 8 9 10 Seldom - Intermittent - Frequent - Constant

Main area(s) of complaint?

_____

_____

When did this episode begin/increase?

_____

_____

What do you believe is causing your symptoms?

_____

_____

Describe the nature of your symptoms. (Deep, Burning, Numbness, Aching, Stiff, etc)

_____

_____

Can you go to sleep without problems? □ Yes □ No Do you awaken because of pain? □ Yes □ No

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Any prior history of current complaints? □ Yes □No If yes, please describe

_____

_____

Prior treatment by a chiropractor for these? □ Yes □No If yes, please list who and when:

1._____

2._____

Please describe what activities aggravate your symptoms:

1. _____ 3. _____

2._____ 4._____

Please describe what activities relieve your symptoms:

1. _____ 3. _____

2._____ 4._____

Have you had any recent imaging / testing? □ Yes □No

If yes, please list type (Xray, MRI, CT, EMG, etc) location and date taken:

1._____ DATE: _____

2._____ DATE: _____

3._____ DATE: _____

General Information:

Handedness: □ L □ R □ Both

Tobacco Use: □ Current Every Day Smoker □Sometimes Smoker □ Former Smoker □ Never been a Smoker

Alcohol Use: □ None □ Social □ Moderate □ Heavy

Treatment History:

Any prior Doctor seen for this condition? □ Yes □ No

Doctor Name: _____ Specialty: _____

Date seen: _____ Referred by: _____

Treatment type: _____

Currently treating? □ Yes □ No Did treatment help you? □ Yes □ No

Referred to another Provider? _____

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Current Medical History:

Current Health Problems (Heart Disease, Diabetes, High Blood Pressure, etc): □ None

_____

_____

_____

Current Medications Taken:

□ Vitamins/Supplements □ None □See Separate List

_____

_____

_____

Are you currently pregnant? □ Yes □ No **If so, what is your due date?** _____

List any known allergies you have had to any medications: □ No known allergies

1)_____ 3)_____

2)_____ 4)_____

Has any doctor diagnosed you with High Blood Pressure? □ Yes □ No

Has any doctor diagnosed you with Diabetes presently? □ Yes □ No

If yes, what kind? □ Type 1 □ Type 2

If yes, was most recent hemoglobin A1c> 9.0%? □ Yes □ No

Past Medical History:

Injuries to Head, Neck, or Back, including Motor Vehicle Accidents or Work Injuries:

_____

Surgeries (Dates & Type): _____

_____

Fractures (Dates & Type): _____

_____

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AUTHORIZATION, CONSENT, & RELEASE

I consent and authorize the providers of Back to Balance Chiropractic Wellness Centers to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits. I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependant during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits directly to Back to Balance Chiropractic Wellness Centers for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient Date

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.**

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

YOUR INSURANCE

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at
the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement. If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered**. We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, there may be a $25.00 fee for any appointment not cancelled at least 24 hours in advance. Also, due to the scheduling of massage therapy, there may be a fee of 75% of our regular massage charges for appointments not canceled at least 24 hours in advance. Please call us as early as possible if you know you will need to reschedule your appointment.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

Our practice is committed to protecting privacy and confidentiality. With my consent, Back to Balance Chiropractic Wellness Centers, may use and disclose Protected Health Information (PHI) about me or my dependant to perform treatment, payment and healthcare operations (TPO).

_____ _____

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Record Release

I, _____/_____,
Patient Name Date of Birth

Here by request my records and/or imaging reports be released from:

_____

_____

_____

and to be faxed/mailed/taken to

Back to Balance Chiropractic Wellness Center

131 Roswell St Ste 101B
Alpharetta, GA 30009

Patient/Guardian _____ Date _____

Witness _____ Date _____