Alexander Spine Center

11705 Jones Bridge Road, Suite D101 Johns Creek, GA 30005 Phone: 678-297-0901

PLEASE PRINT ALL INFORMATION ***Patient Information***

First Name: _____ Last Name: _____ MI: ___ Preferred Name: _____

Date of Birth: ___/___/___ AGE: _____ SSN: ___-___-_____ ( ) Male ( ) Female

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Name of Employer: _____ Occupation: _____

Phone Numbers: ( ) _____ ( ) _____ ( ) _____
(Home) (Work) (Cell)

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Emergency Contact: _____ Relationship: _____ Contact Phone: _____

Primary Care Dr.: _____ & Phone: _____

How were you Referred: _____; if by a patient what is the patient's name: _____

Email Address: _____ May we email you reminders, events and newsletters: __Yes __No

Health Insurance Information: (Please complete if you have insurance.)

Primary Health Insurance:

Company: _____ PPO / HMO / Fed / EMO / POS
Relationship to patient: Self / Spouse / Child / Other _____
Policy #: _____ Group #: _____
Claim #: _____ Insurance Phone: _____

Insured Name: _____
Insured DOB: _____
Insured SSN: _____
Insured Employer: _____

Secondary Health Insurance:

Company: _____ PPO / HMO / Fed / EMO / POS
Relationship to patient: Self / Spouse / Child / Other _____
Policy #: _____ Group #: _____
Claim #: _____ Insurance Phone: _____

Insured Name: _____
Insured DOB: _____
Insured SSN: _____
Insured Employer: _____

Please Read *Before* Signing – Signature on File Statement.

I hereby give my permission to the doctor to perform such procedures and administer treatment as he may deem medically / chiropractically necessary in the diagnosis and / or treatment of my condition. I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed. I authorize use of this form on all of my insurance submissions. I authorize release of information to all of my insurance companies. I authorize payment directly to **Alexander Spine Center**. I permit a copy of this authorization to be used in place of the original. I understand that my insurance coverage is a contract between my insurance co. and myself and that **Alexander Spine Center** will submit claims on my behalf but will not be responsible for filing appeals or disputing rejections. I agree with the above requirements and request that **Alexander Spine Center** submit claims on my behalf. I understand that I am responsible for all charges incurred regardless of my insurance status. I understand that there will be a $25.00 fee for all returned checks.

_____ Patient Signature

_____ Parent / Guardian Signature

_____ Today's Date

Health Record # _____

Alexander Spine Center

11705 Jones Bridge Road, Suite D101, Johns Creek, GA 30005 * 678-297-0901

Confidential Health Questionnaire

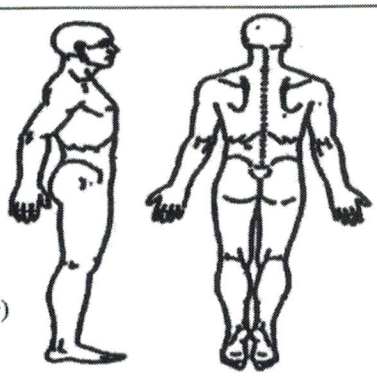
Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Present Complaint(s): _____

1. Have you ever been in an automobile accident? □ No □ Yes, when_____

2. Have you ever been injured at work? □ No □ Yes, when_____

3. Indicate on the drawings below where you have pain/symptoms:



4. Please select all that apply: □Sharp □Dull □Achy □Burning □Stiff
□Numbness □Shooting □Tingly □Radiating □Soreness □Stabbing □Other
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. Intensity of your symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) (*Please circle*)

6. How do you think your problem began?_____

7. How long have you had this problem? _____ days _____ months _____ years

8. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

9. What aggravates your problem?_____

10. What alleviates your problem?_____

11. Have you had this problem before? _____

12. How much has the problem interfered with your work?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

13. How much has the problem interfered with your sleep?
□ Not at all □ A little bit □ moderately □ Quite a bit □ extremely

14. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

15. This problem prevents me from:_____

16. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician □ No one
□ ER physician □ Orthopedist □ Physical Therapist □ Other: _____

17. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

18. What level of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Health Record # _____

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash/skin condition/acne
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss	☐	☐	STD'S
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite	☐	☐	Thyroid Problems
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Excessive Fatigue
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Unusual Hair Growth
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Hair Loss
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Inability to Loose/Gain Weight
☐	☐	Cancer	☐	☐	General Fatigue	☐	☐	Excessive Mood Swings
☐	☐	Tumor	☐	☐	Muscular Incoordination	☐	☐	Hot Flashes or Night Sweats
☐	☐	Asthma	☐	☐	Visual Disturbances	☐	☐	Mental Fog
☐	☐	Chronic Sinusitis	☐	☐	Dizziness / Mental Fog			
☐	☐	Other:_____						

For Females ONLY:

☐	☐	Birth Control Pills	☐	☐	Hormonal Replacement	☐	☐	Pregnancy _____weeks
☐	☐	Heavy/painful Menstrual Cycle	☐	☐	Irregular Menstrual Cycle			

20. Have you ever had any surgery: ☐ No ☐ Yes _____

21. Have you ever been hospitalized? ☐ No ☐ Yes, why_____

22. Have you had significant past trauma? ☐ No ☐ Yes

23. Indicate if you have any immediate family members with any of the following: ☐ Stroke ☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems ☐ Cancer ☐ ALS

24. Anything else pertinent to your visit today? _____

Print Name: _____

Patient / Guardian Signature:_____ Date:_____

Alexander Spine Center

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Johns Creek, GA 30005

Phone: 678-297-0901
Fax: 678-297-0903

Authorization To Pay Physician

I, _____, hereby authorize the _____ insurance company to pay by check/EFT made out and mailed directly to:

Alexander Spine Center
11705 Jones Bridge Road, Suite D101
Johns Creek, GA 30005

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, the balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, I authorize you to make the check out to me and mail it as follows:

_____
C/O Alexander Spine Center
11705 Jones Bridge Road, Suite D101
Johns Creek, GA 30005

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I understand that ultimately I am financially responsible for all services rendered to me.

I hereby give my permission to **Alexander Spine Center** to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby give my permission to **Alexander Spine Center** to file formal grievances with the Georgia Insurance Commissioner when necessary on my behalf, should my insurance company deny payment of all or part of my medical bills.

_____
Patient / Guardian Signature

_____
Today's Date

Alexander Spine Center

Pregnancy Disclaimer – (FOR WOMEN ONLY)

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release Alexander Spine Center from responsibility for potential damage arising from this procedure.

At the present time:

_____ I am sure that I am NOT pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

Date of LMP _____

_____ _____

Patient Signature Today's Date

_____ _____

Witness Signature Today's Date

Alexander Spine Center

11705 Jones Bridge Road, D101, Johns Creek, GA 30005

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Alexander Spine Center. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Alexander Spine Center to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Deidra James about my concerns.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Witness (Office Staff) Date

Authorization to Use or Disclose Protected Health Information

1. I hereby authorize _____ to use or disclose the following protected health insurance information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
   (Name of physician/facility/provider/hospital

2. Patient Name: _____ Date of Birth: _____/_____/_____

   Address: _____
   Street City State Zip Code

3. Information to be disclosed to: _____

4. Disclose the following information for treatment dates: _____ to _____

☐ Complete Records	☐ Consult	☐ Physical Therapy
☐ Abstract	☐ Outpatient Reports	☐ Emergency Reports
☐ Face Sheet	☐ X-ray	☐ Bills
☐ Discharge Summary	☐ Laboratory	☐ History & Physical
☐ Pathology	☐ Super Statement	☐ Last Date of Service

   ☐ Other (Specified) All Insurer reports and records generated as a result of an examination(s) and/or review(s) of client/patient/insured and/or medical documentation relating to the _____ date of loss

5. The above information is being disclosed for purposes of treatment, payment of operations.

6. I understand I may revoke this authorization at any time by requesting such of the above referenced physician/facility/provider/hospital practice in writing, unless action has already been taken in reliance upon it, or during a contestibility period under applicable law.

7. This authorization expires on (or upon) _____
   Insert Applicable Date and/or event

8. _____ _____
   SIGNATURE OF PATIENT Date PRINTED NAME OF PATIENT

9. _____ _____
   (Name of patient's representative) (Relationship to patient or authority to act for patient)

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL APPLICABLE NUMBERED ITEMS ARE COMPLETED.

Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company or other third party payor.

A photocopy of this form shall have the same authority as the original

ALEXANDER SPINE CENTER

11705 Jones Bridge Road, D101
Jones Creek, Ga 30005

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/_____ **Gender: ( ) Male ( ) Female**

Your Employer:_____ Occupation: _____

Employers Address: _____

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

***If more than 3 medications, please continue list on back of page**

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Temp: _____

Blood Pressure:_____/_____ Heart Rate: _____