PATIENT DATA SHEET

General Information

First Name _____

Middle Initial _____

Last Name _____

Suffix _____

Called Name _____

Address _____

City _____

State _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Social Security # _____

Email Address _____

Marital Status Single Married Other _____

Birthdate _____

Referred By _____

Work Status Employed Full-time student Part-time student

Sex: Male Female Language: English Spanish Russsian Other

For Office Use Only

Account Number _____
Account Category _____
Type of Account 1 2 3 4 5 6 7 8 9 Z
Code Set _____
Yearly Deductible _____
Deductible Rest Date _____
Unused Deductible _____
Copay _____
Patient Percentage _____
Household Mailing Yes No
Doctor Number _____
Maximum Charges _____
Max Charge per Day _____
Maximum Visits _____
Max Visits Since Diag _____
Max Treatment Date _____
Full Balance _____
Patient Balance _____
Diagnosis Codes _____

Primary Insurance Coverage Information

Coverage Effective Date _____
Plan Name _____
Coverage Notes

_____

Limitations Notes

_____

Secondary Insurance Coverage Information

Coverage Effective Date _____
Plan Name _____
Coverage Notes

Limitations Notes

_____

Condition Information

When did this condition begin? _____ _____ _____ Gradually Unknown

Have you been treated for this condition before? Yes No
Was Condition Related to Recent Work Injury Claim? Yes No
Was Condition Related to Recent Auto Accident Claim? Yes No
Was Condition Related to Recent Other Accident Claim? Yes No

Acct # :_____

Name: _____ Date of Birth:_____(EHR 1st &2nd Tab)

HISTORY

Past Treatments - List any past treatments you may have had:

Past Conditions - List any past conditions, not already indicated, you may have had including: falls, car accidents, sports injuries, childhood injuries, birth tramas. Especially: Diabetes, Heart Disease and Cancer

Family History - List any family health issues, Especially: Diabetes, Heart Disease, and Cancer.

Social History - List any social history (smoking, drinking, etc.):

Past Medications - List any past medications you may have taken:

Are you currently taking vitamins? If yes, which ones?

Do you have allergies? ❑Yes ❑No If yes, which ones?

Have you ever had any surgeries? ❑Yes ❑No If yes, enter the type and approximate date of surgery:

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

Roswell
Review of Systems

Patient Name: _____ Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

Signature: _____ Date: _____

ROSWELL HEALTH AND INJURY CENTER
1499 Alpharetta Hwy
Suite 100
Alpharetta Ga. 30009
Phone 770-442-3343 Fax 770-576-0152
DR. JOHN A. WEBSTER

MR#_____

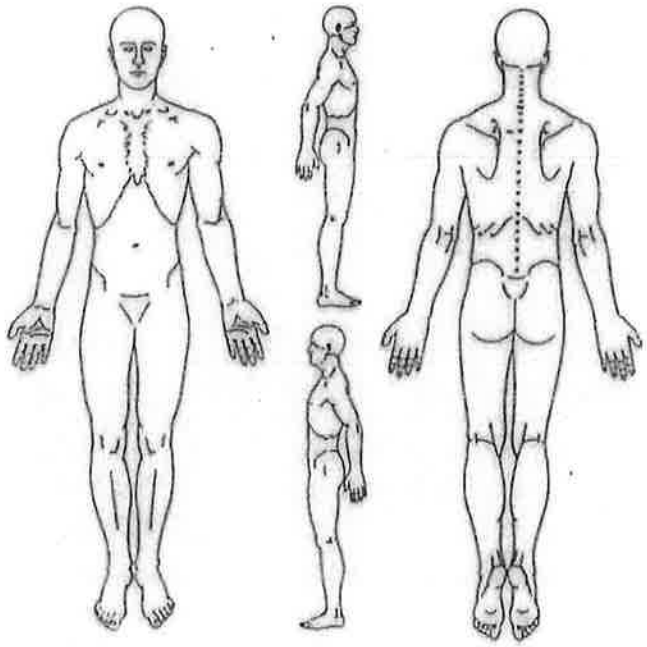
Last Name: _____ **First Name:** _____ **M.I**_____

Primary Care Physician address and phone number_____

PAIN IS DOCUMENTED AS "0" MEANING NO PAIN AND "10" BEING THE WORSE PAIN EVER!

PLEASE PUT A NUMBER IN THE SPACE TO THE LEFT OF ALL THE SYMPTOMS YOU ARE CURRENTLY HAVING

ALSO PUT AN X ON THE MODELS BELOW WHERE YOUR PAIN IS



____ 1.HEADACHES
____ 2. DIZZINESS
____ 3. NECK PAIN
____ 4. NECK STIFFNESS
____ 5. UPPER BACK PAIN
____ 6. SHOULDER PAIN L R
____ 7. ARM OR HAND PAIN L R
____ 8. NUMBNESS OR TINGLING
WHERE? _____
____ 9. MID BACK PAIN
____ 10. ABDOMINAL PAIN
____ 11. LOW BACK PAIN
____ 12. HIP OR BUTTOCK PAIN L R
____ 13. LEG OR FOOT PAIN L R
____ 14.KNEE PAIN L R
____ 15. EAR NOISES
____ 16. SINUS INFECTION
____ 17. VISION PROBLEMS
____ 18. ALLERGIES
____ 19. CHEST PAIN
____ 20. DIFFICULT BREATHING
____ 21. FREQUENT URINATION
____ 22. PROSTATE PROBLEMS
____ 23. ARTHRITIS
____ 24. BURSITIS
____ 25. STROKE

I hereby authorize ROSWELL HEALTH AND INJURY CENTER to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my Chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. First day's fees are due and payable at the time of service.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO ROSWELL HEALTH AND INJURY CENTER FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

_____ _____

Signature of Patient or Guardian authorizing care Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

Other Treatment Options Which Could be Considered may include the following:

- *Over the counter analgesics* The risks of these medications include irritation to the stomach, liver, and kidneys, and other side effects in a significant number of cases
- *Medical care* Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases

Risks of Remaining Untreated: Delay of treatment allows the formation of adhesions, scar tissue, and other degenerative changes .These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult

Unusual Risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction, I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treat, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date

Witness:

_____	_____	_____
Printed Name	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF 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
- The right to request restrictions as to how my health information my be used or disclosed to carry out treatment, payment, or healthcare operations

_____ _____

Patient/Guardian Signature Date

Emergency Contact Information

Name: _____

Phone number: _____

Relation to Patient: _____

I authorize Roswell Health and Injury Center to contact the above-named person(s) regarding my: *Check all that apply*

☐ Medical information including but not limited to diagnosis, treatments, and x-rays

☐ Billing information including but not limited to balance information, cost of treatment, and payments

☐ Location and status in case of an emergency

_____ _____

Patient/Guardian Signature Date

Roswell Health and Injury Center
1499 Alpharetta Hwy, Suite 100
Alpharetta, GA 30009
Phone 770.442.3343 Fax 770.576.0152

John A. Webster, D.C.

RELEASE OF RECORDS

To Whom it May Concern,

Pursuant to Title 31, Chapter 33, of the Official Code of Georgia, I

_____, request that my health records and/or x-rays, or
Patient's Full Name

a copy thereof, being in the custody of _____ be
Clinic, hospital, or doctor's name

released to me personally or released/mailed to:

Roswell Health and Injury Center
1499 Alpharetta Highway, Suite 100
Alpharetta, GA 30009
Phone: (770) 442-3343
Fax: (770) 576-0152

____/____/____ _____
Patient's Birthdate Patient's Signature Date

_____
Witness Date

Records must be released to patient or anyone designated by patient to receive them. Failure to release when written request is provided is a misdemeanor under OCGA 31-3-8, per joint secretary of examination boards, Mr. William G. Miller, on May 19, 1988.