Date:	I.D. NO.

Levinson Chiropractic Center
5457 Roswell Road NE, Suite 102 Atlanta, Georgia 30342
Office: 404-257-0404 Fax: 404-257-0351

Confidential Patient Health Record

PERSONAL HISTORY

E-mail Address: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____/Carrier: _____

Date of Birth: _____ Age: _____ Sex: ___ M ___ F

Social Security Number: _____ Driver's License Number: _____

Business/Employer: _____ Type of Work: _____

Business Phone: _____ Circle One: Married Single Widowed Divorced Separated No. of Children: ___

Name of Spouse: _____ Spouse's Date of Birth _____

Spouse's Employer: _____ Spouse's Cell Phone _____

Business Phone: _____ Type of Work: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Referred To This Office By: _____

Who is responsible for your bill: (Circle One) Self Spouse Workman's Comp Auto Insurance
Medicare Medicaid Personal Health Insurance

CURRENT HEALTH CONDITION

Purpose of This Appointment/Chief Complaint: _____

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 condition: _____ Job Related _____ Auto Related _____ Home Injury _____ Fall Other _____

Date of Accident: _____ Time of Accident: _____

Have you made a report of your accident to your employer: _____ Yes _____ No

Medication you take now: _____ Nerve Pills _____ Pain Killers/Muscle Relaxers _____ Blood Pressure Medicine
_____ Insulin _____ Other: _____

Do you wear a shoe lift? _____ Yes _____No

Do you suffer from any condition other than that which you are now consulting us? _____

_____

PAST HEALTH HISTORY

Please check or describe:

Major Surgery/Operations: _____ Appendectomy _____ Tonsillectomy _____Gall Bladder _____Hernia
_____ Back Surgery _____ Broken Bones _____ Other _____

Major Accidents or Falls: _____

_____

Hospitalization (other than above) _____

_____

Previous Chiropractic Care: _____ None _____ Doctor's Name & Approximate Date of Last Visit: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care. Please enter a check mark in front of all the following signs and symptoms. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS
___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness or Pain in arms/Legs/hands
___ Allergy (What?)
___ Wheezing
___ Neuralgia

GASTRO-INTESTINAL
___ Poor Appetite
___ Poor Digestion
___ Excessive Hunger
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain Over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids
___ Liver Trouble
___ Jaundice
___ Gall Bladder Issues

EYE/EAR/NOSE/THROAT
___ Frequent Colds
___ Poor Vision
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharges
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throat
___ Hoarseness
___ Hay Fever
___ Asthma
___ Tonsillitis
___ Hyperthyroidism
___ Hypothyroidism
___ Sinus Trouble

RESPIRATORY
___ Chronic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing

GENITO-URINARY
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Inability to Control Urine
___ Prostate Trouble

MUSCLE & JOINTS
___ Neck Pain
___ Neck Stiffness
___ Upper Back Pain
___ Middle Back Pain
___ Low Back Pain
___ Painful Tailbone
___ Foot Troubles
___ Spinal Curvature
___ Swollen Joints
___ Tremors
___ Hernia
___ Weakness
___ Twitching

CARDIO-VASCULAR
___ Rapid Heart
___ Slow Heart
___ High Blood Pressure
___ Low Blood Pressure
___ Pain Over Heart
___ Prev. Heart Trouble
___ Swelling of Ankles
___ Poor Circulation
___ Varicose Veins
___ Strokes

SKIN/ALERGIES
___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives/Allergies
___ Eczema
___ Psoriasis

FOR WOMEN ONLY
___ Painful Periods
___ Excessive Flow
___ Irregular Cycles
___ Hot Flashes
___ Cramps/Backache
___ Miscarriage
___ Vaginal Discharge
___ Pregnant at this time
___ Last Pap
By Who: _____
Other: _____
_____

HABITS
___ Smoking ___ pks/day ____
___ Drinking ___ alcohol ____
___ Coffee ___ cups/day ___

EXERCISE
___ None
___ Moderate
___ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	____	____	____	_____	_____
Father	____	____	____	_____	_____
Brother No of __	____	____	____	_____	_____
Sister No of __	____	____	____	_____	_____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?
___ Appendicitis
___ Pneumonia
___ Rheumatic Fever
___ Polio
___ Tuberculosis
___ Whooping Cough
___ Other _____
___ Anemia
___ Measles
___ Mumps
___ Chicken Pox
___ Diabetes
___ Cancer
___ Heart Disease
___ Thyroid
___ Influenza
___ Pleurisy
___ Alcoholism
___ Veneral Infection
___ Arthritis
___ Epilepsy
___ Mental Disorder
___ Lumbago
___ Eczema
___ AIDS

DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient Accepted? ( ) Yes ( ) No ( ) Referred

_____
Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

[ ] Relief Care [ ] Corrective Care [ ] Comprehensive Care [ ] Check here if you want the Doctor to select the type of care appropriate for your condition.

_____ X_____

Date Patient Signature

If this is an accident related injury, please fill out the Accident Form. Thank you!

THE PURPOSE OF
OUR CHIROPRACTIC CENTER
IS TO SUPPORT
EACH INDIVIDUAL
IN ACHIEVING THEIR
OPTIMUM HEALTH

AND TO
EDUCATE THEM
SO THAT THEY MAY
UNDERSTAND HEALTH
AND CHIROPRACTIC
AND IN TURN EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I herby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid to the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient is of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature X_____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

*** * We need a copy of your driver's license and insurance card for our records * ***

As a courtesy to you, we will bill your insurance company on a weekly basis. If a payment is not received after 60 days, you should contact your insurance company and have them make the payment. If, after 90 days, payment is still not received, you will be asked to make payment. The below signed authorization is needed or we can not submit your claims directly to your insurance company. **In any case where your insurance company sends payment directly to you, realize this is done in error and call our office immediately so that we may follow the correct protocol for payment to reach our office.**
"I authorize the Levinson Chiropractic Center to release medical information or any information pertaining to the examination, treatment, history and medical expenses to my insurance company(ies) for the purpose of processing insurance claims"

Patients: Please sign the top portion only:

Insured Name: X _____

Signature: X _____ Date: _____

Please Fill Out Insurance Information

Insurance Company Name: _____
Insurance Company Phone#_____
Policy #:_____
Group #:_____
Policy Holder: _____
D.O.B./SS#/Zip Code:_____

----------For Office Use Only ----------

Verification

Date of Call: _____ Time of Call _____ Contact Person: _____
Reference #_____ _____
What is Primary Network?_____ (if on ActivHC list, use their TIN to verify Ins); ASHN? _____
Chiropractic Coverage: Yes:_____ No:_____ HMO/PPO/POS/Other _____
Effective Date _____
Is Precertification Required? Yes:_____ No:_____ Details:_____

IN NETWORK

Deductible: _____ Used? _____
Carryover? _____
Coverage %: _____
Co-pay: _____
Visits/year: _____ Used: _____
Max $ per year_____ Used: _____
Out of Pocket: I:_____ F: _____

OUT NETWORK

Deductible: _____ Used? _____
Carryover? _____
Coverage %: _____
Co-pay: _____
Visits/year: _____ Used: _____
Max $ per year_____ Used: _____
Out of Pocket: I: _____ F: _____

Claims Address: _____
_____
_____
_____

Other Coverage Information:
Massage Therapy: _____
Supplies/Pillows/Supports: _____
Orthotics: _____
Other information: _____
_____
_____

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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 (Circle one):** Male / Female **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.)

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:_____ Blood Pressure:_____/_____ Pulse: _____