



2050 Marconi Drive
 Suite 125
 Alpharetta, GA 30005
 Phone: (770) 346-8788
 Fax: (770) 343-9948
 atlspinealph@bellsouth.net

Welcome To Atlanta Spine Alpharetta

Step 1: About You

Today's Date: ___/___/___ File #: _____

Patient Name: _____
 LAST FIRST MI

What Do You Prefer To Be Called: _____ Male Female

Birthdate: ___/___/___ Age: _____ S.S. #: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone: _____

Work Phone: _____ Ext: _____

Other Phone: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do You Have Children? Yes No How Many? _____

Step 2: Insurance Info

Co. Name: _____

Address: _____

Phone #: _____

Insured's ID #: _____

Group # (plan, Local or Policy #): _____

Relation: _____ Birthdate: ___/___/___

Insured's Employer: _____

Please Inform Front Desk of Second Insurance Source

Step 3: Reason For Visit

The Reason For This Visit Is A Result Of (Please Circle): Work, Sports, Auto, Trauma, or Chronic
 (Explain What Happened): _____

Please Describe The Pain & Its Location: _____

When Did The Condition Begin? ___/___/___

Is This Condition Getting Worse? Yes No Constant Comes And Goes

This Condition Interferes With (Please Circle): Work, Sleep, or Daily Routine

If So, Please Explain: _____

Have You Had This or Similar Conditions In The Past? Yes No

If So, Where? _____

Have You Ever Been Treated By A Chiropractor Before? Yes No

If So, Whom? _____ Phone #: _____



Step 4: In The Event Of An Emergency

Who Should We Contact? _____
Relation: _____
Home Phone #: _____ Work Phone #: _____
Who Is Your Medical Doctor? _____ Phone #: _____

Step 5: Health History

Are You Taking Any Of The Following Medications?
 Nerve Pills Pain Killers (Including Aspirin) Muscle Relaxers
 Stimulants Blood Thinners Tranquilizers Insulin
 Other(s) _____

Do You Or Have You Had Any Of The Following Diseases Or Conditions?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/ Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/ Joints	Y N Arthritis\

Please List Any Other Serious Medical Condition(s) You Have Ever Had: _____

Please List Anything That You May Be Allergic To: _____

List Previous Surgeries/Treatments With Dates: _____

List Any **Past** Serious Accidents With Dates: _____

Family Health History: _____

Do You: Take Supplements or Vitamins? Yes No / Exercise? Yes No
 Are You On A Special Diet? Yes No / Since: ____/____/____
 Do You Smoke? Yes No / How Much? _____ / How Long? _____
 Are You Wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports
 What Is The Age Of Your Mattress? _____ Is It Comfortable? Yes No
For Women: Are You Taking Birth Control? Yes No
 Are You Pregnant? Yes No / How Long? _____ Nursing? Yes No

Step 6: Account Info

Person Ultimately responsible For Account
 Name: _____
 Relation: _____
 Billing Address: _____
 _____ CITY STATE ZIP
 SSN: _____
 D.L. #: _____
 Work Phone #: _____

Payment Method: Cash Check

Credit Card-Enter Card # Above
 (If Accepted)
 _____ I hereby authorize assignment of my
 Initials insurance rights and benefits directly
 to the provider for services rendered. I fully
 understand I am solely responsible for any
 balance not paid by my insurance company
 (if offered at this office)

- We invite you to discuss with us any questions regarding services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes of the information I have provided.

Signature _____ Date: ____/____/____

Adult Patient Parent or Guardian Spouse