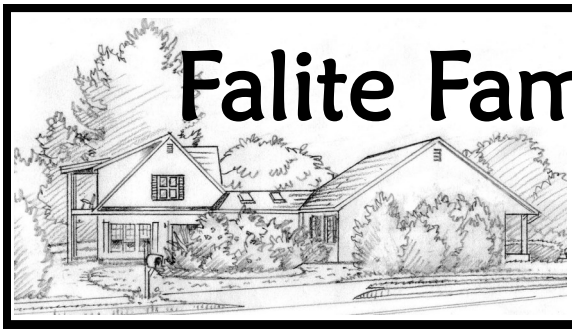

Falite Family Chiropractic

Drs. Dawn & Michael Falite
770-667-2232
2910 Vaughan Dr, Cumming, GA 30041
www.FaliteChiropractic.com

Name:_____ Date:_____

Address:_____ City:_____ Zip:_____

Date of Birth:_____ Age:_____ SS#:_____-_____-_____ Marital Status: M S D W

Occupation:_____ Employer:_____

Phone (home):_____ (work):_____

(cell):_____ email:_____

Spouse's Name & DOB:_____ Spouse's Employer:_____

Names & Ages of Children:_____

Hobbies:_____

Who referred you to our office:_____ Relationship:_____

Name of previous Chiropractor:_____ Last visit:_____

How long did you receive adjustments:_____ Why did you stop care:_____

Reason for consulting our office:_____

Past Trauma:
What accidents have you had? (i.e. car, bicycle, sports, slips/falls, etc.) Please include approximate dates:_____

_____

What fractures or broken bones have you had?_____

Surgery/Illnesses:
What surgeries have you had? (i.e C-section, heart bypass, hysterectomy, tonsillectomy, etc.)
Please include approximate dates:_____

_____

What major illnesses have you experienced? (i.e. pneumonia, cancer, TB, heart attack, stroke, etc.):

_____

OVER

Medication:
Present prescription drugs:_____

Past prescription drugs:_____

Over-the-counter drugs (i.e. aspirin, antihistamines, laxatives, etc.):_____

_____

Your Birth Record:
Birth place: Home / Birth Center / Hospital
Type: Vaginal / C-section
Procedures: Forceps / Vacuum Extraction
Any complications:_____

Current Health:
How would you describe your current health?_____
Do you use any of the following? tobacco / alcohol / coffee / cola / milk / artificial sweeteners
Level of stress: mild / moderate / severe
Do you use any of the following? purified water / vitamins / health foods / organic foods

Financial Information:
Are you planning on using some type of insurance? Yes / No
***If you are planning on using insurance, please provide our office with your policy information.

What method of payment will you be using? cash / check / credit card

By signing below, I understand that I am ultimately responsible for the payment of the balance due for my care in this office.

Patient's signature (or person responsible for account):_____

Please check any of the following symptoms you have had or are having now:

[ ] Headaches / migraines
[ ] Neck pain/tightness
[ ] Shoulder / arm / hand pain
[ ] Grinding in neck
[ ] Sinus trouble
[ ] Allergies / hayfever
[ ] Asthma
[ ] Dizziness / fainting
[ ] Ear infections
[ ] Ringing in ears
[ ] Depression
[ ] Blurred vision
[ ] Lights bother eyes
[ ] Loss of memory
[ ] Fatigue
[ ] Trouble sleeping
[ ] Fibromyalgia
[ ] Loss of balance
[ ] Shooting head pains
[ ] Loss of smell / taste
[ ] Tonsillitis
[ ] Irritability / nervousness
[ ] Thyroid problems
[ ] Facial twitch
[ ] Jaw pain (TMJ)
[ ] Facial pain
[ ] Mid-back pain
[ ] Chest pain
[ ] Shortness of breath
[ ] Anemia
[ ] Ulcers
[ ] Diabetes
[ ] Heart attack / stroke
[ ] Other:_____
[ ] Low blood pressure
[ ] High blood pressure
[ ] Stomach pain / indigestion
[ ] Gall bladder problems
[ ] Intestinal gas
[ ] Low back pain
[ ] Hernia
[ ] Arthritis / swollen joints
[ ] Scoliosis
[ ] Prostate problems
[ ] Bed wetting as child
[ ] Hip / knee / leg pain
[ ] PMS
[ ] Infertility
[ ] Kidney problems
[ ] Constipation

We look forward to helping you!!!

HEALTH CARE AUTHORIZATION FORM

You are being provided with a copy of this Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of your Protected Health Information (PHI) that will occur during your treatment, payment of your bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes your rights and the duties of the Chiropractor with respect to your protected health information. By signing below, you are giving permission to Falite Family Chiropractic (FFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to FFC to use my address, phone number, email and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives and/or other health related information.
- If FFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to FFC to have my name on a sign-in sheet.
- I give permission to FFC to use my photograph on their patient picture bulletin board and/or other marketing materials such as their brochures, website and ads in print media.
- I give permission to FFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochures, on their website or in ads in print media.
- I give FFC permission to treat me in a semi-private room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving FFC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of your care at Falite Family Chiropractic, plus 7 years or until revoked by yourself.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of FFC. The written notice must contain the following information: your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZAITON; the date of your request; and your signature. The revocation is not effective until it is received by the Privacy Official. This AUTHORIZATION is requested by FFC for its own use/disclosure of PHI. *(Minimum necessary standards apply)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, FFC will not refuse to provide treatment, however, it will not be possible for FFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since FFC will be unable to contact me 3) all contact with FFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.* I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____ DOB:_____ Today's Date:_____

Patient's name (please print):_____

Signature:_____ Relationship to Patient:_____