HEALTH FIRST CHIROPRACTIC CENTER, INC
HEALTH AND SPINE CLINIC, CORP.

2475 WINDY HILL ROAD, SE, MARIETTA, GEORGIA 30067-8604 (770) 951-8800 FAX: (770) 951-8803

NAME/NOMBRE:_____
FIRST MIDDLE LAST

HOME ADDRESS:_____
APT# CITY STATE ZIP

HOME #:( )_____CELL #:( )_____WORK #:( )_____

EMAIL:_____DRIVER'S LICENSE #:_____ISSUING STATE_____

BIRTHDATE:_____/_____/_____AGE:_____SOCIAL SECURITY:_____ GENDER: M / F

NAME OF EMPLOYER:_____ADDRESS:_____

(CIRCLE ONE): SINGLE MARRIED WIDOWED DIVORCED SEPARATED OTHER:_____

IN CASE OF AN EMERGENCY:_____
NAME RELATION PHONE #

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IF MINOR CHILD, PARENT/GUARDIAN'S NAME**:**_____RELATIONSHIP TO CHILD**:**_____

PARENT/GUARDIAN'S DATE OF BIRTH:____/____/_____WORK:(____)_____SSN:_____

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WHO IS RESPONSIBLE FOR YOUR BILL? (CIRCLE) SELF WORKERS' COMP. AUTO INS. HEALTH INS OTHER:_____

INSURANCE NAME/SEGURO:_____POLICY OR CLAIM #:_____

POLICY HOLDER'S NAME:_____DOB:_____IF AN ACCIDENT, GIVE DATE:_____

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DOCTORS SEEN FOR **THIS CONDITION**:_____PHONE #:_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:_____
_____

DESCRIBE PROBLEM/DESCRIBA PROBLEMA: _____
_____

PLEASE CHECK THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING:

__HEADACHE/MIGRAINES	__NECK PAIN	__MID BACK PAIN	__SHOULDER PAIN R___ L___
__LIGHT BOTHERS EYES	__STIFF NECK	__LOW BACK PAIN	__PAIN IN BOTH SHOULDERS
__DIZZINESS	__GRINDING SOUND IN NECK	__HIP PAIN R___ L___	__LOSS OF GRIP R__ L___HAND
__RINGING IN EARS	__NECK FEELS OUT OF PLACE	__PAIND DOWN LEG R___ L___	__WRIST PAIN R___ L___
__LOSS OF MEMORY	__CHEST PAIN	__NUMBNESS OF FEET R___ L___	__PINS/NEEDLES R___ L___ ARM
__FATIGUE/TIRED	__SHORTNESS OF BREATH	__ANKLE PAIN R___ L___	__PINS/NEEDLES R__ L__HAND
__LOSS OF SLEEP	__NERVOUSNESS	__KNEE PAIN R___ L___	__PINS/NEEDLES R_ L_ FINGERS
__HANDS FEEL COLD	__LOSS OF__ SMELL __ TASTE	__RIB PAIN R___ L___	__OTHER:_____

As a courtesy to you, insurance is verified for you. Verification of insurance is not a guarantee of payment or benefits. Some of the insurance plans require that your primary care physician refer you to us. If this is the case, you must obtain the referral prior to being seen. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon what type of contract your employer negotiated with that carrier on your behalf. We ask that our patients inform themselves of what those guidelines are. If payment is not received within 60 days, I understand that I am responsible for all charges, regardless of insurance coverage. If my account is past due for over 90 days a fee of $10.00 per month may be added to my account. If my account is turned over for collections, I understand that I will be fully responsible for any court cost and attorney fees.

PATIENT OR GUARDIAN'S SIGNATURE:_____**DATE:**_____

OFFICE USE ONLY: PATIENT ACCOUNT #:_____