PATIENT HISTORY

Date of Birth _____ Age _____ Social Security # _____

Last _____ First _____ Middle Initial _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Your Occupation _____ Employer _____

Spouse's Name _____ Spouse DOB _____ Spouse SSN: _____

Contact in case of emergency _____ Phone _____

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____

Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-15 (1 being no symptoms, 15 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-15 (1 being no symptoms, 15 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you smoke? ☐yes ☐no If yes, how many packs per week? _____

Have you ever smoked in the past? ☐yes ☐no If yes, when did you quit? _____

WOMEN ONLY: Do you take birth control? ☐yes ☐no Are you pregnant? ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons: _____

_____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

_____

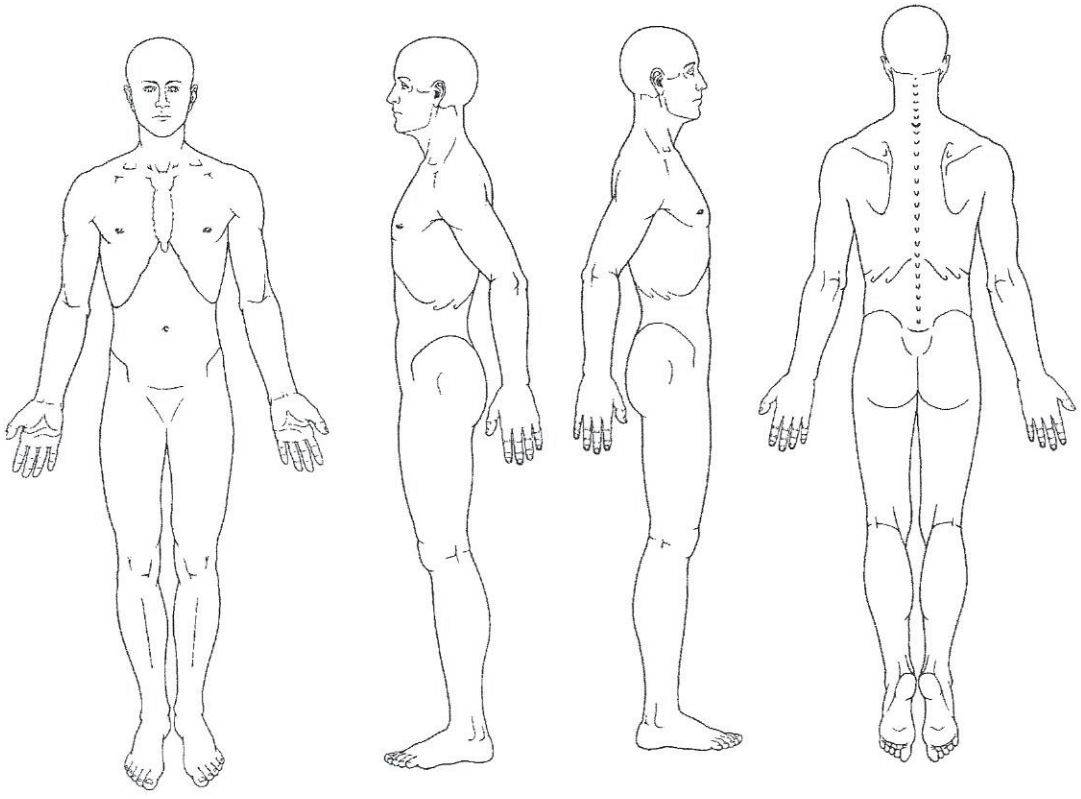
_____

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY

Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Please list all surgeries, injuries, accidents, falls, etc: _____

_____

_____

_____

_____

_____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
☐ Other:				

PATIENT SIGNATURE _____ **DATE** _____

Peter G. Lazarnick, D. C.

486 Bankhead Avenue
Carrollton, GA 30117
770-834-7477

Authorizations and Releases

NAME _____ CASE # _____

_____ **Consent for Treatment**

I, the undersigned, hereby authorize Peter G. Lazarnick, D. C., and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

Patient's Signature_____ Date _____ Witness _____

_____ **Consent for Treatment of a Minor**

I hereby authorize Peter G. Lazarnick, D. C., and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (son/daughter) _____ (child's name) _____.

Patient's Signature_____ Date _____ Witness _____

_____ **X-ray/Medical Records Release**

I have requested the release of records of (patient's name) _____, which are a part of the records at (facility) _____.

I hereby request and authorize you, your employees and agents, to furnish to the person(s) listed below, or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excepts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to: **Peter G. Lazarnick, D. C., 486 Bankhead Avenue, Carrollton, GA 30117**

Patient's Signature_____ Date _____ Witness _____

Peter G. Lazarnick, D. C.

486 Bankhead Avenue
Carrollton, GA 30117

Phone 770-834-7477
Fax 770-834-0251

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Peter G. Lazarnick, D. C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with serving as back up for Peter G. Lazarnick, D. C., including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Lazarnick and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on facts then known, is in my best interest.

I have read, or have read to me the above consent, I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE, IF NECESSARY; I.E., IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

PRINT PATIENT'S NAME	SIGNATURE	DATE
REPRESENTATIVE	RELATIONSHIP	DATE
WITNESS TO PATIENT'S SIGNATURE		DATE

Security and Privacy Statement

The following statement is in response to the new federal guidelines known as HIPAA (Health Insurance Portability and Accountability Act). Public Law 104-191 August 16, 1996. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Our office utilizes an open floor plan; this allows greater interaction between individuals within the practice. Due to this arrangement, personal information concerning your symptoms and general condition may be overheard by other individuals in close proximity to you. X-ray view boxes may have films of our spine in indirect view of others while either being discussed with you, or are being viewed by the doctor for diagnostic purposes. No personal information will ever be intentionally shared. However, private reports containing any sensitive information will be discussed in a separate, private report room. Any private financial discussions can take place in private as well, at patient's request. Most financial arrangements are done this way initially. All patient files are kept under lock and key. No personal information is shared with anyone outside this office without prior written authorization by said patient; examples being attorney request of physician request. We currently do not file electronically so no information from this office is currently on the Internet. Patients may request copies of their records, but we are not legally responsible to supply the actual copy. Patients will need to supply their own copying devices to this office to receive such documents. Not all-patient information is subject to access. We will, on occasion, mail various letters or cards to our patients. This is to include recall cards, statements, newsletters, Christmas cards and personal letters to our patients. We may place a patient's name on our referral board as a thank you from time to time. In order to reschedule missed appointments and as a reminder of current appointments, phone calls will be made and/or messages left. At no time do we use these calls for the transfer of personal information. Patients may request that they are not contacted or be removed from mailing lists. We will make every effort to comply with these requests. This document may be updated as required by federal mandate. Your signature confers you have read and understand our privacy and confidentially policy. Complaints regarding our policies and procedures may be directed to Dr. Peter G. Lazarnick personally. Contact can be made during our normal business hours. We can be reached at 770-834-7477. This document will be kept on file. You may refuse to sign this document. A reason must be given and witnessed.

Signed _____ Date _____

Witness _____

Refusal _____

_____

ACKNOWLEGMENT *of* RECIEPT *of the*

NOTICE of PRIVACY PRACTICES *of*

PETER G. LAZARNICK

herein after referred to as *the Clinic*.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by ***the Clinic*** to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (*please print*) **Date**

_____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative

_____

Please list below the names and your relationship of people to whom you authorize *the Clinic* to release your private health information:

Print Name	**Relationship**

This form will be placed in the patient's chart and maintained for six years.

ChiroHealthUSA
The Network That Works for Chiropractic!

ChiroHealthUSA Plus

DISCOUNT MEDICAL PLAN APPLICATION

THIS FORM SHOULD NOT BE GIVEN TO PATIENTS UNLESS THEY ARE JOINING CHIROHEALTHUSA OR CHIROHEALTH PLUS
You must read important disclosures and sign the reverse side

Date:

Patient Name:

Primary Card Holder Gender: ◯ Male ◯ Female

Primary Card Holder Date of Birth:

Dependents' Names:
(Spouse, Domestic Partner, Dependent Children up to age 26, Parents in the Household over age 60, and any other IRS Dependent)

Patient Address:

City:

State: **Zip:**

Phone:

Email:
(Contact information will not be shared, sold or distributed)

FOR CLINIC USE ONLY

City:

Date entered in Online Membership Link:

By:

ChiroHealthUSA
120 Stone Creek Blvd., Suite 100, Flowood, MS 39232
1-888-719-9990

◯ ***CHUSA PROCESSED***

PAYMENT INFORMATION

◯ **YES! I want ChiroHealthUSA PLUS for $89.00 for a ONE YEAR membership to include Chiropractic, Vision, Dental, Pharmacy, Lab and Imaging Discounts! NOTE: Not available in Alaska, California, Vermont and Washington.**

◯ **YES! I want ChiroHealthUSA for discounted Chiropractic Care Only for $49.00 for a ONE YEAR membership.**

You may renew your agreement by continuing annual payments as applicable for your plan. The brochure for your program contains a description of the benefits you will receive and is incorporated by reference and is a part of this document. PLEASE READ YOUR BROCHURE BEFORE SIGNING THIS DOCUMENT.

HSA and FSA accounts for payment of membership fees is not permissible.

Check and Credit card information will be destroyed once transaction is completed.

Check #:

Credit Card Type: ◯ Visa ◯ MC ◯ Amex ◯ Disc. **Card#:**

Card ID (CVV2/CID) Number: **Exp. Date:** **Billing Zip Code:**

Name on Card: **Signature:**

DISCLOSURES

These discount medical, health, and drug plans are NOT insurance, health insurance policies, Medicare Prescription Drug Plans or qualified health plans under the Affordable Care Act. These plans (The Plans) provide discounts for certain medical services, pharmaceutical supplies, prescription drugs or medical equipment and supplies offered by providers who have agreed to participate in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). The range of discounts for medical, pharmacy or ancillary services offered under The Plans will vary depending on the type of provider and products or services. The Plans do not make and are prohibited from making members' payments to providers for products or services received under The Plans. The member is required and obligated to pay for all discounted prescription drugs, medical and pharmaceutical supplies, services and equipment received under The Plans, but will receive a discount on certain identified medical, pharmaceutical supplies, prescription drugs, medical equipment and supplies from providers in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). Members will have free access to providers without restrictions such as waiting periods, notification periods, etc. except for hospital discounts. The Plans do not offer discounts on hospital services. The Discount Medical Plan Organization is Alliance HealthCard of Florida, Inc., P.O. Box 630858, Irving, TX 75063. ChiroHealthUSA members may call 1-888-719-9990 for more information or visit www.chirohealthusa.com for a list of providers. ChiroHealthUSA Plus members may call 1-800-220-7752 for more information or visit www.chirohealthusaplus.com for a list of providers. The Plans will make available before purchase and upon request, a list of program providers and the provider's city, state and specialty, located in the member's service area. Alliance HealthCard of Florida, Inc. does not guarantee the quality of the services or products offered by individual providers. The fees for The Plans are specified in the membership agreement. You have the right to cancel your membership at anytime. If you cancel your membership within 30 days of the effective date, you will receive a full refund of your membership fees other than money paid by you to a provider. To cancel your ChiroHealthUSA Plan you must, verbally or in writing, notify ChiroHealthUSA at 1-888-719-9990, 120 Stone Creek Blvd., Suite 100, Flowood, MS 39232. To cancel your ChiroHealthUSAPlus Plan you must, verbally or in writing, notify Alliance HealthCard of Florida, Inc. at 1-800-220-7752, P.O. Box 630858, Irving, TX 75063. Any complaints should be directed to Alliance HealthCard of Florida, Inc. at the address or phone number above. Upon receipt of the complaint, member will receive confirmation of receipt within 5 business days. After investigation of the complaint, Alliance HealthCard of Florida, Inc. will provide member with the results and a proposed resolution no later than 30 days after receipt of the complaint.

Note to DE, IL, LA, NE, NH, OH, RI, SD, TX and WV consumers: If you remain dissatisfied after completing the complaint system, you may contact your state department of insurance . You may contact Alliance HealthCard of Florida, Inc. for department of insurance contact information.

Note to MA consumers: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00

Signature:

SPACE INTENTIONALLY LEFT BLANK