

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: _____

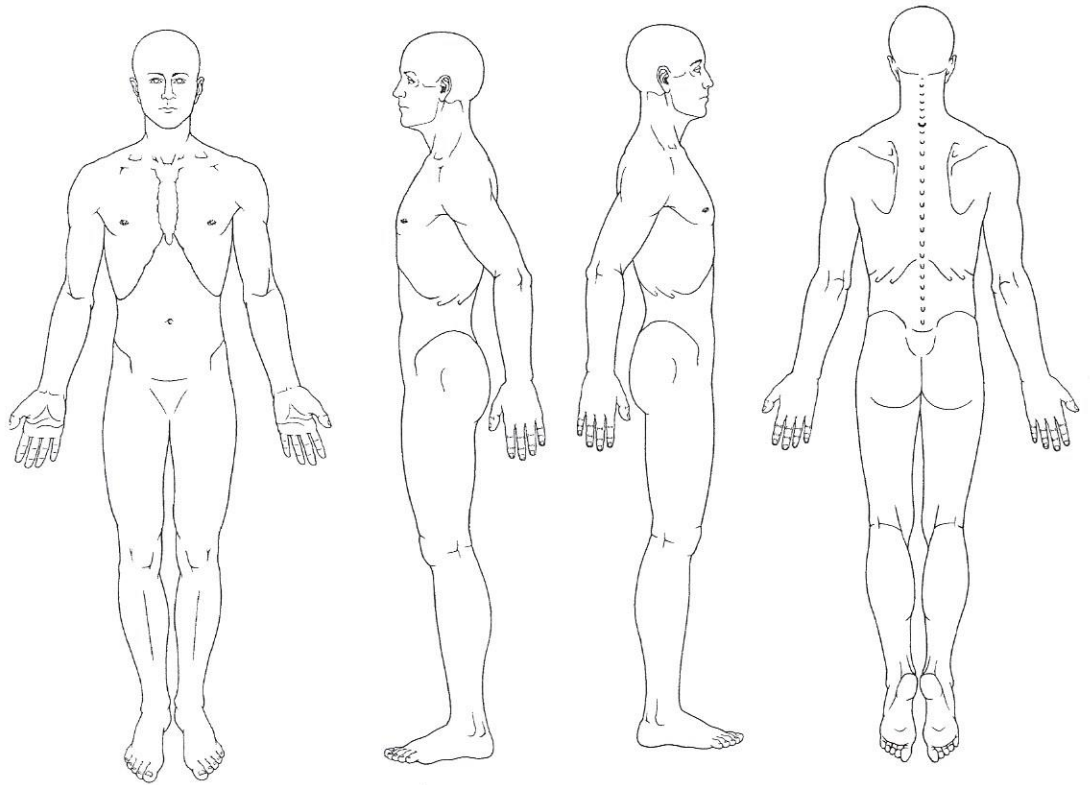
Please list any medications or vitamins you are currently taking:

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:

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

PATIENT SIGNATURE _____ **DATE** _____

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.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **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.**

Patient's Signature _____ Date _____ Witness _____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date _____ Witness _____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Peter G. Lazarnick, D. C., the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

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 excerpts 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 Highway, Carrollton, GA 30117**

Patient's Signature _____ Date _____ Witness _____

Phone 770-832-2226
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 had 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 your 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 confidentiality 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 770-832-2226. 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 _____

**ACKNOWLEDGMENT of RECEIPT 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.