Welcome to ***Belanger Chiropractic Life Center***

(PLEASE PRINT NEATLY) ***Your Medical Record at our office requires the following information.***

Patient Information

Legal First Name:	**MI:**	**Last Name:**	**Date of Birth:**

Female Male _____

Sex Social Security #

Marital Status, Circle: Single Married Widowed Divorced

Spouse Name:_____

Address: Street City State Zip

_____ _____ Home Phone: _____

Cell Phone, Txt Msg? Yes No **Email Address**

Work Phone: _____

Emergency Contact Info

Contact Name:_____ **Contact Phone:**_____

How did you hear about us? / Who were you referred by? _____

Purpose for contacting us? _____

Other doctors seen for this condition: □ YES □ NO If yes, doctors' names and prior treatments: _____

_____

Other health problems? _____

Patient Demographics

Due to recent changes in the healthcare industry, we are asked to gather the following information from our patients.

- Occupation:_____ Employer Name & City, State:_____
- Preferred Language(s): __English __Spanish __French __German __Russian __Indian __Japanese __Chinese __Korean
- Race: __American Indian or Alaska Native __Native Hawaiian or Pacific Islander __Black or African American __Hispanic or Latino __Asian __White or European American __Decline to Answer __Not Listed:_____
- Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Decline to Answer

Insurance Information

We will make a copy of your insurance card(s). However, please complete the following information.

Primary Policy Holder's Info

Insurance Company:	
Policy Holder's Name (First MI Last):	
Policy Holder's DOB:	Policy Holder's SS#:
Policy Holder's Employer:	

Is patient the Policy Holder? Yes No

If No, who is the Policy Holder: Spouse Parent Employer Other

Secondary Policy Holder's Info

Secondary Insurance Company:	
Policy Holder's Name (First MI Last):	
Policy Holder's DOB:	Policy Holder's SS#:
Policy Holder's Employer:	

Is patient the Policy Holder? Yes No

If No, who is the Policy Holder: Spouse Parent Employer Other

I authorize the release of any medical or other information necessary to process all claims performed by any of the above said physicians. I also request payment of government and/or private benefits to myself or to the party who accepts assignment on this and all future claims. We are filing your insurance as a courtesy to you. Therefore if your insurance fails to pay for any treatment on your behalf, you will be responsible for the balance due. By signing below, you agree to the above terms and conditions.

→ Signature of Patient:_____ Date:_____ / _____ / _____

(or responsible party if patient is under the age of 18 years)

BELANGER CHIROPRACTIC LIFE CENTER

Specializing in Atlas Orthogonal Chiropractic Sheila E. Belanger, D.C.
1003 East Freeway Dr. SE **Conyers, GA 30094**
Phone 770-760-1394 Fax 770-760-8414

PATIENT HISTORY FORM

(PLEASE PRINT)

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name: _____ Date: _____

Health History

Have you tested positive for: HIV/AIDS? __No **__Yes or Hepatitis?** __No **__Yes: __A __B __C __D __E**

Do you smoke? __Never __Former Smoker __Current/Every Day Smoker __Current/Some Days Smoker

Have you…been diagnosed with Hypertension? __No **__Yes,** Name of Treating Physician:_____

…been diagnosed with Diabetes? __No **__Yes,** Circle: **Type I Type II,** Name of Treating Physician:_____

Do you have any allergies? __Food __Environmental __Medication

List type of allergy & reaction: _____

_____

Are you <u>currently</u> taking any medications (including OTC) / vitamins / supplements? __No **__Yes,** Please list below:

If you have brought a list with you, let the front desk make a copy, and write "SEE ATTACHED" below.

Name	Strength/Dosage	Frequency	Prescribing Physician
		__3x Daily __2 x Daily __1x Daily __As Needed __Other:	
		__3x Daily __2 x Daily __1x Daily __As Needed __Other:	
		__3x Daily __2 x Daily __1x Daily __As Needed __Other:	

Check any of the following ailments / conditions that pertain to you.

□ Abdominal cramps	□ Allergies:_____	□ Breathing difficulty	□ Ankle swelling	□ Arthritis
□ Bladder trouble	□ Blood clots	□ Colitis	□ Bursitis	□ Cancer:_____
□ Chest pain	□ Clicking jaw	□ Diarrhea	□ Constipation	□ Convulsions
□ Depression	□ Diabetes	□ Excessive thirst	□ Diverticulitis	□ Dizziness
□ Earaches	□ Eating disorder	□ Gallbladder problems	□ Fainting	□ Fatigue
□ Forgetfulness	□ Frequent nausea	□ Heart condition:_____	□ Gas / bloating	□ Headaches / Migraines
□ Hearing difficulty	□ Heartburn	□ Irregular heartbeat	□ Irritable bowel syndrome	□ Hemorrhoids
□ High blood pressure	□ High cholesterol	□ Pain between shoulders	□ Lupus	□ Jaw pain / TMJ
□ Liver problems	□ Lung problems / congestion	□ Spasms / cramps	□ Paralysis:_____	□ Lymphedema
□ Numbness / tingling in extremities		□ Tendonitis	□ Prostate problems	□ Sinus problems
□ PMS	□ Poor / Excessive appetite	□ Other:_____	□ Stress	□ Stroke
□ Sleep disorder:_____		□ Other:_____	□ Varicose veins	□ Vision problems
□ Swelling:_____				
□ Vomiting	□ Weight trouble			

Family History:_____

Previous Chiropractic Care: ☐ NO ☐ YES Chiropractor Name: _____

Date of Last Visit: _____/_____/_____ Reason: _____

Is there any posibility you might be pregnant? ☐ NO ☐ YES How many weeks?_____

Please enter the date of the first day of your last menstrual period. (Month & Day) _____

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NAME : _____

List any previous accidents, injuries (ex: car accidents, sports injuries) or surgeries: _____

_____

List any major illnesses or broken bones: _____

Main Complaint(s)	How Intense? (0 - least; 10 - worst)	How Frequent?	Is it Getting Worse, Better, or Staying Same?
1. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS
2. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS
3. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS
4. _____	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	W B SS

When did you first notice this/these problem(s)?_____

How does this condition intefere with normal living and working? _____

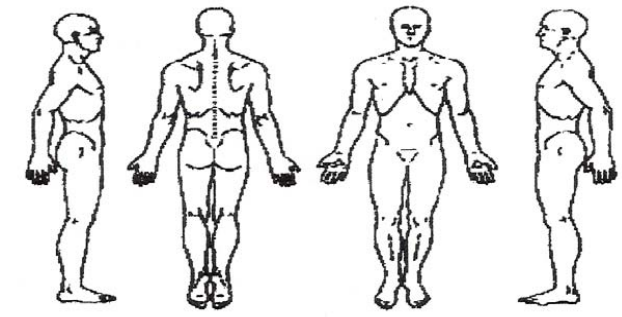
_____

Was your condition caused by: ☐ Auto ☐ On job injury Employer: _____ ☐ Other _____

Describe: _____

_____

Please use the diagram to mark the areas of your body which are causing you pain



NOTICE OF PRIVACY PRACTICES: EFFECTIVE April 14, 2003 As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPPA): This notice describes how health related information about you may be disclosed, and how you can get access to this information. We are required by law to maintain confidentiality of health information that identifies you as well as your health status. Your Protected Health Information (PHI) can be used for treatment, payment, and health care operations. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization except to the extent that your physician or the practice has taken action in reliance on the use or disclosure indicated in the authorization. Upon written request, you have the right to request that our practice communicate with you about your health and related issues in a particular manner. You may also request us, in writing, to amend your health insurance information if you believe it to be incorrect or incomplete. You have the right to request a restriction, in writing, in our use or disclosure of your PHI for treatment, payment, or health care operations and for non-treatment or operations purposes. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. We reserve the right to revoke any voluntary agreement to restrict the use or disclosure of your PHI that we may enter into.

→ Signature of Patient:_____ Date:____ / ____ / ____

(or responsible party if patient is under the age of 18 years)

Belanger
CHIROPRACTIC LIFE CENTER

1003 East Freeway Dr. SE Conyers, GA 30094

Office: 770.760.1394 Fax: 770.760.8414

Assignment & Release: Treatment

I hereby authorize and release Dr. Sheila E. Belanger, DC / Belanger Chiropractic Life Center and staff/assistants to administer physical examination, x-ray studies, chiropractic care, massage therapy, and any other treatment deemed medically necessary in my case.

If signing on behalf of a Minor, I attest that I am a Legal Parent/Guardian of the named Minor Patient.

Patient's or Parent's/Guardian's Signature: _____ **Date:**_____