GATLIN CHIROPRACTIC AND WELLNESS

PATIENT INFORMATION

Date: ____________________

SSN: ____________________

Name: ____________________

Address: ____________________

City: ____________________

State: __________ Zip: __________

Date of Birth: __________ Age: ______

Gender: ☐ Male ☐ Female ☐ __________

Email: ____________________

Phone Number: ____________________
☐ Home ☐ Work ☐ Cell

☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Occupation: ____________________

Employer/School: ____________________

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Minor

INSURANCE

Insurance Company: ____________________

Subscriber ID#: ____________________

Group #: ____________________

Insured Name: ☐ Self ☐ __________

Secondary Insurance? ☐ No ☐ Yes, complete below

Insurance Company: ____________________

Subscriber ID#: ____________________

Group #: ____________________

Insured Name: ☐ Self ☐ __________

ACCIDENT INFORMATION

If visit is due to an accident, complete below:

Type of accident: ☐ Auto ☐ Work ☐ __________

Accident date: ____________________

Attorney/Claim Adjustor info: ____________________

____

How did you hear about us? ____________________

IN CASE OF AN EMERGENCY, CONTACT:

Name: ____________________ Relationship: ____________________

Home Number: ____________________ Cell Number: ____________________

CONDITION INFORMATION

Describe your pain: ____________________

When did it start? ____________________

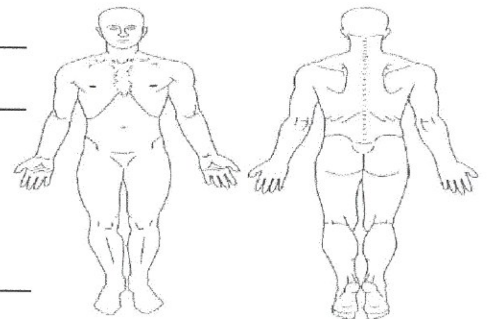
What caused it? ____________________

Is your condition getting worse? ☐ Yes ☐ No ☐ Unknown

Rate your pain on a scale of 0-10: __________

How often do you have the pain? ____________________

Mark an X where you hurt



Is your pain? ☐ aching ☐ stiffness ☐ shooting ☐ cramping ☐ dull ☐ sharp ☐ numbness/tingling ☐ other__________

Does your pain interfere with? □ work □ sleep □ daily routine □ recreation □ ____________________

What makes it worse? □ walking □ driving □ sitting □ bending □ standing □ lying down □ turning □ exercising

What makes it better? □ ice □ heat □ rest □ stretching □ medicine □ massage □ ______________

Have you tried any other treatment? □ No □ Yes, ____

REVIEW OF BODY SYSTEMS

Are you currently experiencing?

- □ Fatigue
- □ Unexplained changes in weight
- □ Changes in vision or hearing
- □ Mouth or throat sores
- □ Swelling in hands or feet
- □ Leg pain with walking
- □ Shortness of breath
- □ Wheezing
- □ Difficulty swallowing
- □ Constipation or diarrhea
- □ Changes in bowel or bladder habits
- □ Fainting/passing out
- □ Involuntary movement/tremors
- □ New or changes to moles/skin lesions
- □ Anxiety, depression, insomnia
- □ Easily bruised
- □ Unexplained swollen areas
- □ Joint swelling
- □ Other ____

HEALTH HISTORY

Have you ever been to a Chiropractor? □ No □ Yes, why? ______________________________

Check if you have/had any of the following:

- □ Asthma
- □ Bleeding disorder
- □ Cancer
- □ Diabetes
- □ Esophageal varices
- □ Gout
- □ Heart disease
- □ Hepatitis, liver disease
- □ Hernia
- □ Herniated disc
- □ High Blood Pressure
- □ High cholesterol
- □ HIV/AIDS
- □ Kidney disease
- □ Multiple Sclerosis
- □ Osteoarthritis
- □ Osteopenia
- □ Pacemaker
- □ Pinched nerve
- □ Prostate problems
- □ Prosthesis
- □ Psychiatric care
- □ Rheumatoid arthritis
- □ Stroke/ TIA
- □ Thyroid problems
- □ Tumor/growth
- □ Ulcers
- □ Other ____

Are you pregnant? □ No □ Yes, due date ______________________________

Do you exercise? □ None □ Few times per month □ Few days per week □ Daily

How do you sleep? □ Back □ Side □ Stomach

What is your work activity? □ sitting □ standing □ lifting □ computer work □ light labor □ heavy labor

Do you smoke/vape/dip? □ No □ Yes, how much? ______________________________

What is your stress level? □ Light □ Moderate □ High Reason? ____________________

Please list any of the following:

Past falls, head injuries: ______________________________

Broken bones: ______________________________

Prior Surgeries: ______________________________

Allergies: ______________________________

Medication, vitamins, supplements ______________________________

____

Patient or Guardian Signature ______________________________ Date ______________

Authorization for the Release of Medical Records

I, ______________________________, hereby request and authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and is good until revoked by me in writing. A copy of this authorization is just as valid as the original.

Organization authorized to release information:

____

____

Organization authorized to receive information:

Gatlin Chiropractic and Wellness
1800 St. John Ave.
Dyersburg, TN 38024
*Phone 731-288-9628 * Fax 731-288-9653*

Please provide the following information:

- ✧ Entire record
- ✧ X-ray reports
- ✧ CT/MRI reports
- ✧ Other_________________________

Purpose of disclosure: Treatment and/or Payment

Patient Name __________________________ DOB ________________

Patient or Guardian Signature____________________ Date__________

If signed by a representative or guardian, state relationship to patient ________________
If signing for a minor patient, I hereby state that I have the legal right to and that my parental rights have not been revoked by a court of law.

FINANCIAL POLICY

All charges, including insurance co-pays and deductibles must be paid on the date of service. Any patient with a balance of $100 or more must pay that balance in order to be seen. All payments not received within 60 days of service date are subject to interest and may be turned over to a collection agency. If you are sent to a collection agency, you are responsible for all charges, interest and fees incurred by us and the collection agency. After hour office visits will be charged a $50 fee on top of your regular charges. If you have insurance, we will file your claim for you. We cannot guarantee coverage. We will attempt to confirm your benefits, but your insurance company has final approval of payment. **You are ultimately responsible for any balance remaining after your insurance company has considered your claim.**

Assignment of benefits - By initialing here___ and signing below, you are authorizing us to bill your insurance company directly on your behalf.

If you do not have insurance, we offer several payment options and plans. Please ask us for details.

HEALTH AND PRIVACY POLICY

We are dedicated to maintaining the privacy of your health information according to federal and state law. These laws require us to provide you with notice of privacy practices and to inform you of your rights and our obligations regarding your health information. By initialing here___ and signing below, you acknowledge that you voluntarily consent to receive medical treatment and health care services provided by our office staff and that you have been given the opportunity to review and that you understand and agree to the Notice of Privacy Practices of Gatlin Chiropractic, which describes our policies regarding the use and disclosure of your protected health information created or received by us.

NO SHOW AND CANCELLATION POLICY

Due to high patient demand and limited availability of appointments, if you "no show" or cancel less than 4 hours before your appointment time, you may be charged a $25 cancellation fee before being seen again. For every block of time that is not used because someone did not show up or canceled short notice, time is taken away from another patient needing care. You may call the office, email us or respond to your appointment reminder to cancel and/or reschedule your appointment. We understand that there are sometimes emergencies, and will consider waiving the fee in certain situations.

Patient or Guardian Signature______________________________ Date ____________