

Porter Family Chiropractic Center

2655 Dallas Hwy. Suite 110 ♦ Marietta, Georgia 30064 ♦ Phone (770) 427-1889 ♦ Fax (770) 427-7513

MEDICARE PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form accurately and completely. **Thank You.**

Date _____ Home Phone (____) _____

Full Name _____ SSN _____

Address _____ City _____ Zip Code _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Occupation _____ Employer _____ Office Phone (____) _____

Employer Address _____ City _____ State _____

Name of Spouse _____ Phone (____) _____

How did you hear about our office? _____

LIST PRESENT PROBLEM AREAS AND INJURIES:

1. _____
2. _____
3. _____

List other Doctor (s) consulted for present complaints and injuries:

Name _____ What Type of Doctor _____ When consulted _____

Diagnosis _____ Treatments / x-rays _____

How long did you see the Doctor? _____ How frequently? _____

Results _____

What Surgeries have you had? Type/ When/ Doctor/ Remarks _____

List former serious accidents and falls; (auto, work, sports,other) Please explain accident, give dates, and treatment received: _____

Broken Bones _____

List medications and/or diet supplements _____

Signature _____

Date _____

Full Name: _____ Height: _____ Weight: _____

How will you be paying for today's visit? Cash / Check / Credit Card

ASSIGNMENT AND RELEASE – I, the undersigned, assign directly to Dr. Porter all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand and agree that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate the recommended care plan and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of default of payment, I further agree to pay any and all collection fees including interest.

Date Patient Signature
PAYMENT RESPONSIBILITY – I understand that I am financially responsible for all charges. If I suspend or terminate the recommended care plan and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of default of payment, I further agree to pay any collection fees incurred, including interest.

Date Patient Signature
↓ **For Office Use Only** ↓

Exam I.

Date: _____ **P.O.P.** _____

MVA / INJ / NA **Chiro Y / N** **Ref:** _____
O: _____
P: _____
Q: _____
R: _____
S: _____
T: _____
Dx: _____

Exam II.

Date: _____ **P.O.P.** _____

MVA / INJ / NA **Chiro Y / N** **Ref:** _____
O: _____
P: _____
Q: _____
R: _____
S: _____
T: _____
Dx: _____

CERVICAL

C	Subluxation Level C	739.1
7	Tension Headache	307.81 S
8	Headache	784.0 S
9	Cervicalgia	723.1 S
1	Root Lesions	353.2 M
10	Cervicobrachial	723.3 M
2	Brachial Neuritis	723.4 M
11	Torticollis	723.5 M
3	Myalgia / myositis	729.1 M
4	Neck sprain / strain	847.0 M
5	Displaced disc	722.0 L
6	Degenerated disc	722.4 L

THORACIC

T	Subluxation Level T	739.2
7	Pain in thoracic	724.1 S
8	Backache – unspec.	724.5 S
1	Root Lesions	353.3 M
2	Thoracic neuritis	724.4 M
3	Myalgia / myositis	729.1 M
4	Sprain / strain	847.1 M
5	Displaced disc	722.11 L
6	Degenerated disc	722.51 L
	AT LEVEL _____	
<input type="checkbox"/>	_____	

LUMBO-SACRAL

L	Subluxation Level L	739.3
S	Sacrococcygeal	739.4
P	Pelvis	739.5
7	Lumbago	724.2 S
8	Backache	724.5 S
1	Root Lesions	353.4 M
2	Lumbosacral neuritis	724.4 M
3	Myalgia / myositis	729.1 M
4	Sprain / strain L	847.2 M
4S	Sprain / strain SI	846.0 M
9	Sciatica	724.3 L
5	Displaced disc	722.10L
6	Degenerated disc	722.52L