AGEE

Dr. Dwight L. Agee

Dr. Lauren P. Cobb

CHIROPRACTIC AND WELLNESS CENTER, P.C.

NEW PATIENT INFORMATION

Name(Last) _____ (First) _____ (MI) _____ Nickname" _____

Address:_____City_____

State:_____ Zip:_____ Date of Birth:_____ Age:_____

Social Security # _____ Marital Status: S M W D Gender: M F

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____) _____ College Student: Yes / No

Responsible Party: _____ Relationship: _____

Date of Birth: _____ Address:_____ City:_____

State:_____ Zip:_____

E-Mail: _____ Number of Children:_____

Place of Employment: _____ Occupation: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____

How did you hear about us? TV Phone Book Newspaper Website Ins. Co. Sign

Friend/Family Member: _____ Other: _____

In Case of Emergency Please Contact: _____ Relationship: _____

Phone Number (_____)_____

Assignment, Lien, and Authorization

I, _____(Patients Name) hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to AGEE CHIROPRACTIC AND WELLNESS CENTER, P.C. (the "center") such sums as benefits, health and accident, benefits workman's compensation benefits, or any other insurance benefits obligated to reimburse me or form any settlement judgment or verdict on my behalf as may be necessary to adequately protect said center. I understand that I remain personally responsible for the total amounts due to the center for their services. I further understand and agree this assignment, lien and authorization does not construe any consideration for the center to await payments and they may demand payments from me immediately upon rendering services at their option. I understand that I am financially responsible to the center for all charges not covered by my insurance company. I further agree that in the event of non-payment, I will bear the cost of collection fees (331/3% of balance), and/ or court cost and reasonable legal fees, should this be required. I authorize the center to release any information pertinent to my case to my insurance company, adjuster, or attorney or 3rd party-review board, employer- to facilitate collection under this Assignment, Lien and Authorization. I agree that the able mentioned center may be given power of attorney to endorse/sign my name on ant and all check for payment of services rendered. I hereby authorize the center (or whomever they may designate as assistants), to administer such treatment as is necessary, and to perform the appropriate therapy, manipulation, and additional diagnostic procedures as considered chiropractically necessary on the basis of findings. This serves as a long-term authorization that applies to all occasions of service until it is revoked.

_____ _____ _____

Patient Signature Date Witness Signature

Agee Chiropractic Center, P.C. Contact Information

Listed below are the persons, including all of my medical doctors, who are involved in my care with whom you may share my protected health information regarding my treatment or payment issues:

Name/Relationship/Phone Number: _____

_____

X_____ _____

Patient Signature (or Parent if Minor Child) Date

Agee Chiropractic Center, P.C. Consent for Purposes of Treatment, Payment and Healthcare Operations

I _____ (Name of Individual) consent to Agee Chiropractic Center's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general health care operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or the treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of healthcare to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of t treatment, payment or healthcare operations of the Practices, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to restriction that I request, the restriction is binding on the Practice. I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my right and the Practice's duties regarding the types of uses and disclosures of my Protective Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has active in reliance on this consent.

X_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

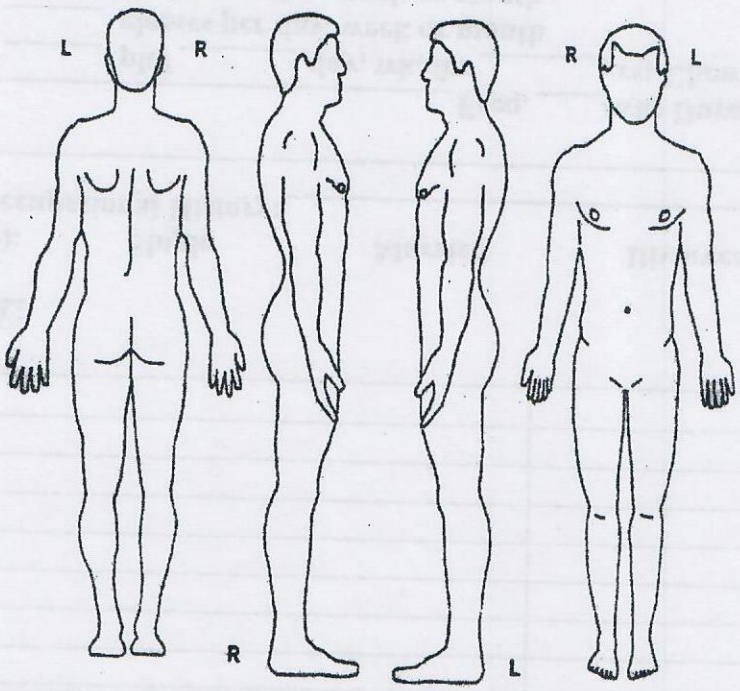
I, _____(Patients Name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Agee Chiropractic Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice.

_____ _____ _____

Patient Signature Date Witness Signature

PATIENT NAME: _____ DATE: _____ PN: _____

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



REVIEW OF SYSTEMS

Please mark an X beside any of the symptoms/conditions listed below that you CURRENTLY are experiencing.

___Weakness
___Fatigue
___Fever
___Headaches
___Sleep Loss
___Weight Loss
___Nausea
___Wheezing
___Hearing Loss
___Bowel/Bladder Problems
___Earache
___Bloody Stool
___Sinus/Hay Fever
___Heat/Cold Intolerance
___Dizziness
___Vision Problems
___Glasses/Contact Lens
___Sexual Dysfunction
___Swallowing Difficulties
___Speech Problems/Hoarseness
___Excessive Sweating

___Arthritis
___Bursitis
___Foot Trouble
___Poor Posture
___Chronic Cough
___Spinal Curvature
___Frequent Colds
___Tingling/Numbness
___Constipation
___Frequent Urination
___Inability to Control Bladder
___Memory Problems
___Fainting
___Painful Menstruation
___Joint Pain/Swelling/Stiffness
___Excessive Hunger/Thirst
___Palpitations
___Clumsiness
___Muscle Pain/Cramps
___Irritable
___Diabetes

___Heart Problems
___High Blood Pressure
___Heart Murmurs
___Poor Circulation
___Swelling of Ankles
___Chest Pain
___Depression/Nervousness
___Difficult Breathing
___Diarrhea
___Hemorrhoids
___Kidney Infection or Stones
___Loss of Appetite
___Vomiting
___Loss of Interest or Energy
___Loss of Consciousness
___Asthma
___Thyroid Problem
___Back or Neck Pain
___Stress (Emotional)
___ Seizures or Convulsions
___ Easy Bruising or Bleeding

_____

_____

PAST HISTORY

I. PAST MEDICAL HISTORY:

Prior MAJOR Illnesses: _____

_____

Prior Surgeries/Operations: _____

_____

_____

Prior Hospitalizations: _____

_____

Current Medications: _____

_____

Allergies (Drug/Food): _____

Prior MAJOR Injuries (MVA, WC, SLIP/FALL, BROKEN BONES): _____

_____

_____

II. FAMILY HISTORY:

*** Please tell us if there is a History of Cancer, Diabetes, Cardiac Problems, Stroke, Blood Pressure Problems, Headaches, Neck Pain, Back Pain or Surgeries in your FAMILY.**

Family History	Living? Medical problems if any:	Deceased? Cause of death:	Age
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Children			
Children			

III. SOCIAL HISTORY:

Marital Status (Circle): Single Married Divorced Widowed

Current Employment/Occupational History: _____

_____

Exercise: Type: _____ **Freq.** ____**/wk; Duration** _____ **Min. / Hrs;** ____

Tobacco: NO / YES _____ **pk /** _____**day, wk, for** _____ **yrs; Chew** _____ **yrs; Pipe**_____ **yrs**

Caffeine: NO / YES _____ **glasses per day, week or month**

Alcohol: NO / YES _____ **glasses per day, week or month**

Sleep Interrupted? NO / YES _____ **x's / night for** _____ **mo, yrs**

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____