

Brown Chiropractic Clinic

1330 Atlanta Hwy · Cumming, GA 30130 · 770-887-7234

DR. MICHAEL A. PURPURA

Director

Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. **PLEASE PRINT.**

Today's Date _____

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status: S M W D No. of Children _____

Cell Phone _____ E-mail _____ Height _____ Weight _____

Your Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone _____ Your SS# _____ Driv Lic# _____

Do you have health insurance where you work? Yes ___ No ___ Plan/Group # _____

Insurance Company _____

Name of Spouse or Parent _____ Birthdate _____

Spouse employed by _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Office phone _____ Spouse SS# _____ Driv Lic# _____

Does your spouse have health insurance at work? Yes ___ No ___ Plan/Group# _____

Describe the Major Complaints that bring you to our office _____

Is your condition due to an accident? Yes ___ No ___ Date of Accident _____

Type of accident? Auto ___ Work/On Job ___ At Home ___ Other _____

Have you ever been in an Auto Accident? Past Year ___ Past 5 years ___ Over 5 years ___ Never _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse or Guardian's Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Insurance Cases: On all insurance, the deductible must be met in the beginning unless prior arrangements are made.

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HEALTH QUESTIONNAIRE

Name: _____

Date: _____

List all your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever been in an industrial injury or any other injury for which you received treatment? When?

Please check the conditions you have or have had:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Venereal Disease |

FAMILY HISTORY:

Age

Health Problems or Cause of Death

Mother:

Father:

Mother's mother:

Mother's father:

Father's mother:

Father's father:

Brothers:

Sisters:

Children:

Please check (x) all present symptoms

Name: _____

CARDIOVASCULAR

- | | | |
|---|---|--|
| <input type="checkbox"/> general swelling | <input type="checkbox"/> chest pain | <input type="checkbox"/> blue or purple skin |
| <input type="checkbox"/> swelling in legs | <input type="checkbox"/> pounding heart beats | <input type="checkbox"/> blue or purple nailbeds |
| <input type="checkbox"/> swelling in face | <input type="checkbox"/> heart "jumps" | <input type="checkbox"/> fainting |
| <input type="checkbox"/> swelling around eyes | <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> hypertension |

VERTEBROBASILAR

- | | | |
|--|---|--|
| <input type="checkbox"/> double vision | <input type="checkbox"/> dizziness without nausea | <input type="checkbox"/> loss of memory |
| <input type="checkbox"/> loss of coordination | <input type="checkbox"/> blurred vision | <input type="checkbox"/> inability to form words (talk plainly) |
| <input type="checkbox"/> irregular muscle movement | <input type="checkbox"/> fainting spells | <input type="checkbox"/> periods of blindness in one eye |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> stroke | <input type="checkbox"/> areas of abnormal sensations such as burning etc. |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> diabetes | <input type="checkbox"/> areas of numbness |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> pain over the heart | <input type="checkbox"/> blood vessel disease (phlebitis, etc.) |
| <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> cold hands and / or feet | <input type="checkbox"/> check if you smoke |
| <input type="checkbox"/> hardening of the arteries | <input type="checkbox"/> areas of numbness | <input type="checkbox"/> check if any of your family members have had a stroke |
| <input type="checkbox"/> areas of muscle weakness | <input type="checkbox"/> arthritis of the neck | <input type="checkbox"/> check if you are taking birth control pills. |
| <input type="checkbox"/> dizziness with nausea | <input type="checkbox"/> previous neck or head injury | |

MUSCULOSKELETAL SYSTEM

HEAD

- | | | |
|---|---|--|
| <input type="checkbox"/> unusually frequent headaches | <input type="checkbox"/> vertigo | <input type="checkbox"/> loss of taste |
| <input type="checkbox"/> unusually severe headaches | <input type="checkbox"/> light-headedness | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> head feels heavy | <input type="checkbox"/> loss of smell | <input type="checkbox"/> dizziness |

NECK

- | | | |
|---|--|---|
| <input type="checkbox"/> pain in neck | <input type="checkbox"/> pinched nerve in neck | <input type="checkbox"/> popping sounds in neck |
| <input type="checkbox"/> neck pain w/o movement | <input type="checkbox"/> neck feels out of place | <input type="checkbox"/> limited neck movement |
| <input type="checkbox"/> swelling in neck | <input type="checkbox"/> muscle spasms in neck | |
| <input type="checkbox"/> stiff neck | <input type="checkbox"/> grinding sounds in neck | |

SHOULDERS

- | | | |
|--|--|---|
| <input type="checkbox"/> pain in shoulders (R-L) | <input type="checkbox"/> tension in shoulders | <input type="checkbox"/> can't raise arm |
| <input type="checkbox"/> pain across shoulders | <input type="checkbox"/> muscle spasm in shoulders | <input type="checkbox"/> above shoulder level |
| | | <input type="checkbox"/> over head |

ARMS & HANDS

- | | | |
|--|--|--|
| <input type="checkbox"/> pain upper arm | <input type="checkbox"/> sensation of pins & needles | <input type="checkbox"/> hands cold |
| <input type="checkbox"/> pain forearm | <input type="checkbox"/> in arms | <input type="checkbox"/> swollen joints in fingers |
| <input type="checkbox"/> pain in hands | <input type="checkbox"/> in fingers | <input type="checkbox"/> sore joints in fingers |
| <input type="checkbox"/> pain in fingers | <input type="checkbox"/> fingers go to sleep | <input type="checkbox"/> loss of grip strength |

MID BACK

- | | | |
|---|--|---|
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> dull ache | <input type="checkbox"/> muscle spasm in mid back |
| <input type="checkbox"/> pain between shoulder blades | <input type="checkbox"/> pain from front to back | |
| <input type="checkbox"/> sharp stabbing pain | <input type="checkbox"/> pain over kidney area | |

LOW BACK

- | | | |
|--|--|--|
| <input type="checkbox"/> low back pain | <input type="checkbox"/> low back feels out of place | <input type="checkbox"/> muscle spasms in low back |
|--|--|--|

HIPS, LEGS & FEET

- | | | |
|---|---|---|
| <input type="checkbox"/> pain in buttocks | <input type="checkbox"/> pins & needles in legs | <input type="checkbox"/> swollen ankles |
| <input type="checkbox"/> pain down leg | <input type="checkbox"/> numbness in leg | <input type="checkbox"/> swollen feet |
| <input type="checkbox"/> knee pain | <input type="checkbox"/> numbness in toes | |
| <input type="checkbox"/> leg cramps | <input type="checkbox"/> cold feet | |

HEALTH REVIEW

Name: _____

SKIN/HAIR/NAILS

- eczema
- itchy skin
- dry scalp
- oily scalp
- rough, scaly skin
- dry skin
- oily skin
- psoriasis
- yellow skin
- bruise easily

- paper thin nails
- pale skin
- nail biting
- baldness

EYES

- blurring of vision
- double vision
- eyes fatigue easily
- excessive tearing
- lack of tearing
- light bothers eyes

- excessive itching
- pain in eyeball

EARS

- loss of hearing
- pain in ears
- discharge from ears
- vertigo

- ringing in ears

NOSE/NASOPHARYNX/SINUSES

- unusual nasal discharge
- nose bleeds
- pressure over eyes
- pressure under eyes
- obstruction of nose
- frequent colds
- sinusitis
- nasal allergies

- loss of sense of smell
- any trauma to nose

MOUTH AND THROAT

- pain in mouth
- pain in throat
- bleeding gums
- cavities
- abscessed teeth
- dentures

- difficulty swallowing
- changes in voice

RESPIRATORY

- shortness of breath
- can't breath while lying down
- can't sleep while lying down
- dry cough
- productive cough
- coughing up blood

- wheezing

GASTROINTESTINAL

- poor appetite
- constant nibbling
- difficulty in swallowing
- indigestion
- can't eat some foods
- nausea & vomiting
- jaundice
- abdominal pain

- change in bowel habits
- diarrhea
- constipation
- hemorrhoids

GENITOURINARY

- Urination is frequent
 normal
 infrequent
- the amount is high
 normal
 low
- need to get up at night to urinate
 - abnormal intense desire to urinate
 - difficulty starting to urinate
 - decreased output
 - pain on urination
 - dribbling

- blood in urine
- cloudy urine
- lack of bladder control
- abdominal pain

VENEREAL DISEASE

- AIDS
- syphilis
- gonorrhea

- other

SOCIAL HISTORY

- smoking
- other tobacco use
- alcohol use
- drink coffee or tea
- My family stress is severe
 moderate
 minimal
 none

- My job stress is severe
 moderate
 minimal
 none

- Diet is: balanced
 not balanced
- Rest is: sufficient
 not sufficient
- Recreation is: sufficient
 not sufficient

How do you like your work?

- I like it very much
- It's ok
- I hate it
- crave salt

- nervousness
- irritability
- fatigue
- depression
- generally feel run-down
- crave sweets

WOMEN ONLY

- painful period
- premenstrual symptoms
- vaginal discharge
- spotting
- irregular periods
- lumps in breasts

of pregnancies _____

of deliveries _____

**CONSENT FOR TREATMENT
AND
AUTHORIZATION TO PERFORM X-RAYS**

Date _____ Time _____ AM
PM

I have been informed by Dr. Michael A. Purpura that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Michael A. Purpura to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: _____

Witness: _____

To the best of my knowledge, I am NOT pregnant, and the above named Doctor has my permission to x-ray me for diagnostic interpretation.

Signed: _____

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Assignment for Direct Payment to Doctor

I hereby instruct and direct the Insurance Company to pay by check made out and mailed directly to:

The Brown Clinic
Dr. M.A. Purpura
1330 Atlanta Hwy.
Cumming, Georgia 30040

the Professional or Medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward charges for Professional Services rendered by Dr. Michael A. Purpura of the The Brown Clinic. The payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in the current manner, any balance of said Professional Service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize Dr. Michael A. Purpura to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case, and hereby release him of any consequence thereof.

Dated at the Brown Clinic this _____ day of _____, 20 _____.

Signature of Policy Holder

Signature of Witness

Date

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Insurance Policy

Dear Patients:

As you know, there has been a revolution in the insurance industry with managed care, HMO's and PPO's.

Our policy has always been, and will continue to be, to assist you in any way we can with your insurance coverage.

However, your insurance policy is a contract between you and your insurance company. We cannot guarantee your insurance company will pay for your Chiropractic care. Except for our managed care patients, you will be responsible for any unpaid chiropractic services that are denied by your insurance company.

We will file one claim per treatment period, free of charge. If any additional insurance filings are required, there will be a five dollar charge per claim.

For our managed care patients, we will follow all procedures as required by your plan to get your claims paid. However, most managed care plans are restrictive in respect to the amount of service allowed. As soon as we are informed that your managed care plan will no longer cover additional treatment, you will be notified and given the option of continuing care at this facility under a cash paying agreement. We have many payment plans available to suit your individual needs and budget.

Thank you for choosing the Brown Chiropractic Clinic for your health care.

Sincerely,

Dr. Michael A. Purpura

Patient Signature: _____

Date: _____

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Office Policy Regarding Insurance Assignment

Our office is pleased to accept insurance assignment as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company, and you are fully responsible for any amount not paid by your insurance.

Our office policy with regards to assignment is as follows:

1. By taking your insurance assignment, we have to wait for payment. This courtesy may be withdrawn if circumstances warrant it.
2. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.
3. We will bill your insurance on 7 to 14 day cycles as long as you are receiving Chiropractic care at this office.
4. You agree to pay the percentage amount of your responsibility as you go along unless other arrangements are made with our office manager prior to treatment. (i.e., if your insurance pays 80% of the bill, you pay 20% on each visit or every Friday if you have several treatments scheduled in one week.)
5. You are required to sign and “Authorization to Pay Physician” form and any other assignments documents required by your insurance company.
6. Our office DOES NOT guarantee that your insurance will pay. Although we will make every attempt at the beginning of your health care to receive verification of your policy and what it covers, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill.
7. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. We will, however, provide you and your insurance company with all necessary information to process your claim.
8. If you understand and agree with all of the above policies, please sign your name below and we will accept your insurance assignment.

Patient Signature: _____ Date: _____

Witness: _____