Marietta: 770-565-2882 Powder Springs 770-439-0198
www.cobbwellnesscenters.com

Please Fill Out COMPLETELY. The more information we have, the better we can help you. Thank you.

Patient Registration – PERSONAL INJURY *(please print clearly)*

First Name _____ MI____ Last Name _____ Date___/___20___

Address _____City _____ State _____ Zip _____

Date of Birth_____/_____/_____ Age _____ Social Security #_____-_____-_____

Drivers License #_____ State Issued _____

Email Address_____

Home Phone (____)-_____-_____ Cell Phone (____)-_____-_____Work Phone (____)-_____-_____

Occupation_____ Employer _____

□ Married □ Single □ Domestic Partnership

Spouses Name: _____ # of Children_____

Occupation_____ Employer _____ Work # _____

Emergency Contact_____ Relationship_____ Phone:(____)_____-_____

Your Health Insurance Company _____Phone Number (____)-_____-_____

Name of Insured: _____ Relationship to you: _____

ID # _____Group # _____

Person Responsible for Charges_____ Phone # _____

Accident History

If involved in auto accident please complete the following:

Your Auto Insurance Carrier _____ Policy Number _____

Phone Number (_____) - _____ - _____

Do you have **Med**ical **Pay**ment Insurance: ☐ No ☐ Yes If yes, Amount $:_____

Other Party's Auto Insurance Carrier _____ Phone Number:_____

Claim Number _____

Do you have an Attorney: ☐ No ☐ Yes Name _____ Phone # _____

Please Describe Your Accident and Put a Check On Each Line That Applies

A. My accident happened on: ____/____/_____
B. I was in the: __driver's seat, __front passenger seat __ back seat on the __left __right.
C. The crash came from: ___behind ___ in front ___ left side ___ right side.
D. ____I was wearing my seatbelt. I was ___stopped ___moving.
E. My foot __was __ was not on the brake. ____I hit my head. ___I was unconscious.

F. Make and Model of car I was in _____ Year _____.
The estimate of damage to that car is $_____ The car was towed ☐ Yes ☐ No
G. Make and Model of the other car(s) involved _____
H. Was the other car citied for accident? ☐ Yes ☐ No ☐ Don't know
I. ☐ I went to the Emergency Room. ☐ I did not got to the Emergency Room.
☐ I was taken in an Ambulance. Which Hospital?_____
Did the Hospital take X-rays / CT / MRI? (circle images taken) ☐ No Images Taken
___ I did see other doctors or health care professionals since my crash.
J. Name of other Doctor/Clinic consulted since your accident _____

K. **Major Complaint** _____
L. ☐ I hit other parts of my body in this accident? _____

M. I had pain right away ☐ Yes ☐ No
N. Are you symptoms ☐ Improving? ☐ Getting Worse? ☐ Same? ☐ Other?_____
N. I missed work due to the accident ☐ Yes ☐ No How Many Days _____

PLEASE EXPLAIN HOW YOUR ACCIDENT HAPPENED:_____
_____
_____
_____

Personal Health History

I am being treated by a:
☐ Chiropractor ☐ Medical Doctor ☐ Massage Therapist ☐ Other

Allergies I have: _____

I am Pregnant ☐Yes ☐ No Date Due _____

Please list hospitalizations and any surgeries that you may have had: Dates

_____

_____

List all medications you are currently taking:_____

Do you Smoke? ☐ Yes ☐ No If yes, how much per day?_____
Do you consume alcohol? ☐ Yes ☐ No If yes, what and how much per week? _____
What type of exercise do you perform on a daily basis? ☐None ☐Moderate ☐Heavy :_____

Has Anyone in Your Family Had These Health Problems?

__ Anemia	__ Stroke	__ Psychological Disorder	__ Glaucoma
__ Asthma	__ Epilepsy	__ Diabetes	__ Tuberculosis
__ Hay fever	__ Cancer	__Heart Disease	__ High Blood Pressure

Review of Symptoms

Height _____Weight _____ Weight 1 yr. Ago _____ Max. Weight _____ When _____

Please Circle ALL the letters that apply to each item:

Y= a condition you have now. **P**= a condition you had in past but not now. **N**= a condition you never had.

Headache	Y P N	Sputum	Y P N
Neck Pain	Y P N	Spit up Blood	Y P N
Mid Back Pain	Y P	Asthma	Y P N
N		Bronchitis	Y P N
Low Back Pain	Y P N	Pneumonia	Y P N
Chest Pain	Y P N	Emphysema	Y P N
(Please circle ALL that apply)		Difficulty Breathing	Y P N
Right/Left Shoulder Pain/ Numb	Y P N	Shortness of Breath	Y P N
Right/Left Arm Pain/Numb	Y P N	Heart Disease	Y P N
Right/LeftHand/WristPain/Numb	Y P N	Angina	Y P N
Right/Left Buttock Pain/Numb	Y P N	High Blood Pressure	Y P N
Right/Left Thigh Pain/Tingling	Y P N	Swollen Ankles/Stomach	Y P N
Right/Left Leg Pain/Tingling	Y P N	Hip/Joint Replacement	Y P N
Right/Left Foot/Toes Pain/Numb	Y P N	Nausea	Y P N
Spasms	Y P N	Vomiting	Y P N
Dizziness	Y P N	Constipation	Y P N
Blurry Vision	Y P N	Blood in Stool	Y P N
Motion Restriction	Y P N	Gas/Bloating	Y P N
Trouble Sleeping	Y P N	Liver Disease	Y P N
Anxious/Fearful Driving	Y P N	Hemorrhoids	Y P N
Night Sweats	Y P N	Abdominal Pain	Y P N
Head Injury	Y P N	Stomach Ulcer	Y P N
Impaired Vision	Y P N	Gall Bladder	Y P N
Corrected Vision	Y P N	Painful Urination	Y P N
Depression	Y P N	Urinary Frequency	Y P N
Tearing/Dryness	Y P N	Ligament or Tendon repair	Y P N
Double Vision	Y P N	Kidney Stones	Y P N
Jaw Pops/Clicks/Painful	Y P N	Blood in Urine	Y P
Cataracts	Y P N	N	
Impaired Hearing	Y P N	Joint Pain/Stiffness	Y P N
Ear Ringing	Y P N	Arthritis	Y P N
Earaches	Y P N	Broken Bones	Y P N
Frequent Colds	Y P N	Muscle Spasms	Y P N
Sinusitis	Y P N	Deep Leg Pain	Y P N
Postnasal Drip	Y P N	Blood Clots in Legs	Y P N
Change in Taste	Y P N	Fainting	Y P N
Thyroid Problems	Y P N	Seizures	Y P N
Cough	Y P N	Paralysis	Y P N

Muscle Weakness	Y	P	N	Prostate Disease	Y P N
Numbness/Tingling	Y	P	N		
Coordination Difficulties	Y	P	N		
Depression	Y	P	N	**Females Only**	
Anxiety	Y	P	N	I am Pregnant _____ Yes _____ No	
Mood Swings	Y	P	N	Age menses began _____	
Memory Loss	Y	P	N	Age menses ended _____	
Drug/Alcohol Abuse	Y	P	N	Breast Lumps	Y P N
Afraid of Being in a Car	Y	P	N	Painful Menses	Y P N
Thyroid Problems	Y	P	N	Sexual Difficulties	Y P N
Knee Surgery	Y	P	N	Spotting	Y P N
Excessive Thirst	Y	P	N	Birth Control	Y P N
Excessive Hunger	Y	P	N	Irregular Cycles	Y P N
Anemia	Y	P	N	Average bleeding length _____	
Easy Bleeding	Y	P	N	Average cycle length _____	
				Breast Pain	Y P N
				Nipple Discharge	Y P N
				PMS Symptoms	Y P N
Males Only				Menopausal Symptoms	Y P N
				Vaginal Dryness	Y P N
Hernias	Y	P	N	Vaginal Discharge/Sores	Y P N
Testicular Masses	Y	P	N		
Testicular Pain	Y	P	N	Number of pregnancies _____	
Sexual Difficulties	Y	P	N	Number of live births _____	
Penile Implant	Y	N	N	Number of miscarriages _____	
Discharge/Sores	Y	P	N		

Are you HIV positive / AIDS?
☐ YES ☐ NO ☐ Don't Know

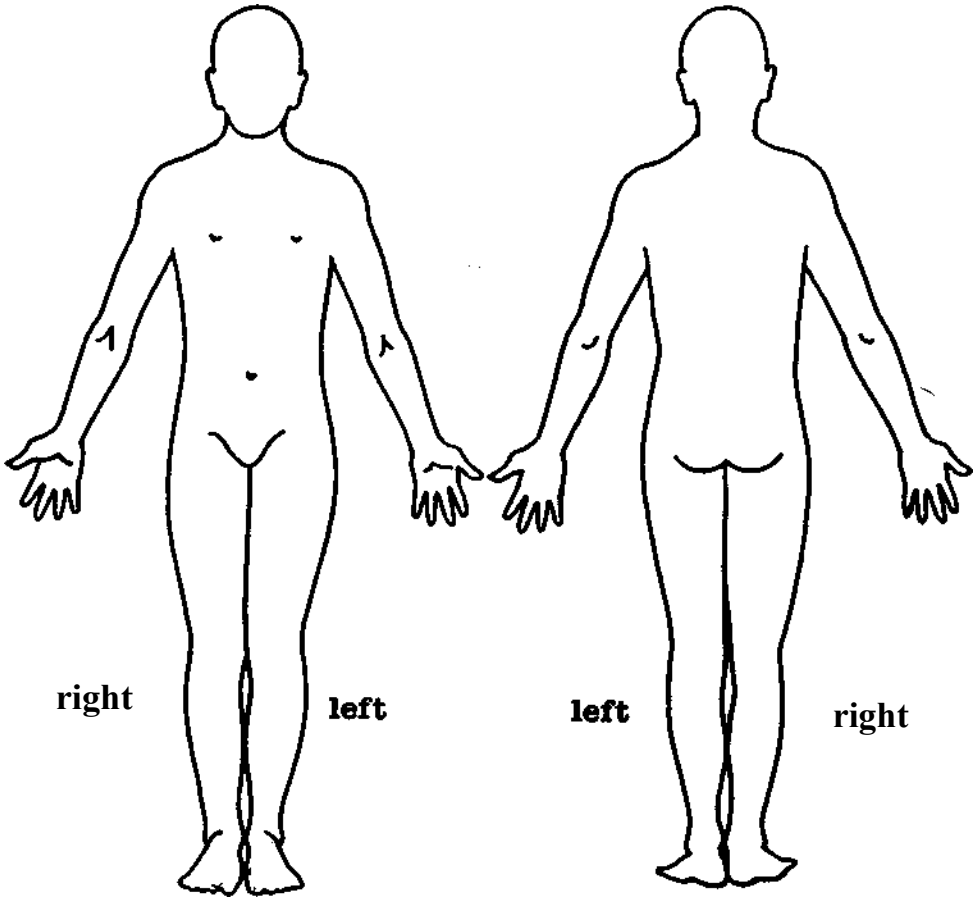
Are there any additional health concerns or questions that you may have?

_____
_____
_____
_____
_____
_____

Use the picture below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, aching or weakness.

Numbness, Pins & Needles: **N** Aching pain: **A**

Burning: **B** Weakness: **W**



Please rate your discomfort on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt).

Location Pain rating

1. _____
2. _____

3. _____

AUTHORIZATION FOR CARE
ASSIGNMENT OF INSURANCE BENEFITS AND ATTORNEY LEIN

This is an agreement between the undersigned patient and Marietta Healthcare.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Marietta Healthcare will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Marietta Healthcare will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care that my fees for professional services rendered to me by Marietta Healthcare will be immediately due and payable. *I agree to accept responsibility for whatever is not covered or accepted by the insurance company; this will include any part of my deductible which has not been met, co-pays or disallowed services.*

I hereby authorize Marietta Healthcare to treat my condition, as the clinician deems appropriate including the use of diagnostic testing and prescribed treatment modalities. Original x-rays taken at Marietta Healthcare will remain the property of Marietta Healthcare, being on file where they may be seen at any time while a patient of this office. Should I require copies of the films, I also agree to pay for the cost of duplication. Marietta Healthcare will not be held responsible for any pre-existing medically diagnosed conditions.

I authorize and direct the insurance company, and/or my attorney, *to pay directly to Marietta Healthcare* such sums as may be due and owing Marietta Healthcare for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I understand that if my treatment is the result of a personal injury, that Marietta Healthcare may have to provide additional documentation, depositions, and testimony. Because of this, I agree to pay Marietta Healthcare the full amount of all services at their usual and customary fees notwithstanding any agreements Marietta Healthcare may have with any other insurance companies/Health Maintenance Organizations, Preferred Provider Organizations, Point of Service carriers or healthcare entities or carriers of any kind. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks received for payment of my doctor bill.
I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.
I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all costs of such collections efforts, including but not limited to all reasonable court costs and all attorney fees. I grant Marietta Healthcare my permission to contact me in regards to my appointments and leave messages on my home, cell, or office.

_____ _____
Patient Name Person Authorizing Care if other than Patient

_____ _____/_____/_____
Signature **Date**

_____ _____/_____/_____
Witness Date

_____, being attorney of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Marietta Healthcare.

_____ _____/_____/_____
Attorney's Name (Please Print) Date

Attorney's Address

_____ _____

Attorney's Signature Attorney's Phone Number