

REGISTRATION

Date _____

Patient

Home Phone

cell #

Last Name

First Name

Initial

Street Address

City.

State

Zip

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Single☐ Married☐ Widowed☐ Separated

☐ Divorced

Social Security #:

email address:

Insured's Name

Last Name

First Name

Initial

Relationship To Insured : ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name _____		Occupation _____
	Address _____		Phone _____
	City _____	State _____	Zip _____
SPOUSE	Name _____ Last Name First Name Initial		
	Birthdate _____ Social Security # _____		
	Employer Name _____ Occupation _____		
	Address _____ Phone _____		
	City _____	State _____	Zip _____
PATIENT INSURANCE INFORMATION	Please ☒ any and all insurance coverage you or your spouse has applicable in this case. ☐ MEDICARE ☐ BLUE SHIELD ☐ AUTO ACCIDENT ☐ MEDICAID ☐ MAJOR MEDICAL ☐ UNION PLAN ☐ BLUE CROSS ☐ WORKER'S COMPENSATION ☐ OTHER BCBS I.D. # _____ MEDICARE/MEDICAID I.D. # _____ MAJOR MEDICAL OR AUTO INSURANCE _____ Date of accident _____ Insurance Company Name _____ Adjuster _____ Address/Phone _____ Claim # _____ Policy # _____ Effective Date _____		
SPOUSE CO-INSURANCE INFORMATION	MAJOR MEDICAL ONLY Insurance Company Name _____ Address/Phone _____ Policy # _____ Effective Date _____		
MEDICAL AND LEGAL INFORMATION	Present Complaint _____ Known Medical Problems _____ Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician _____ Person to contact in emergency (Name and Phone #) _____		Attorney _____ Address _____ Phone _____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with _____ Name of Insurance Company and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. Signature of Insured/Guardian _____ Date _____		

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Patient Name: _____ **Acct#:** _____

Attorney: _____ **Case Manager:** _____

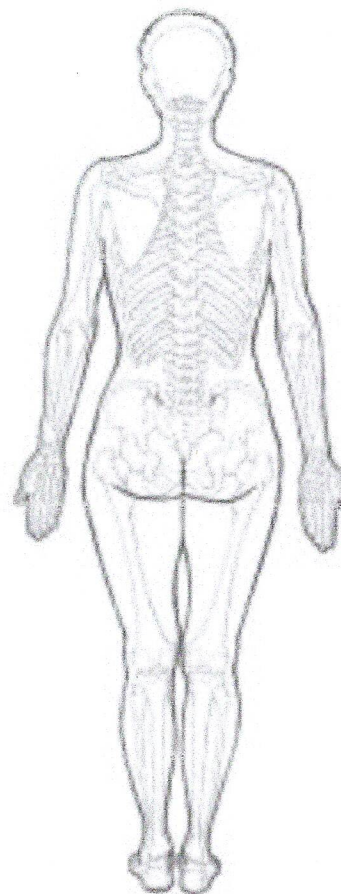
Auto Accident: _____ **Date of Accident:** _____ **State:** _____

Auto/Med Pay: _____ **Claim #:** _____

Treatment Plan/ # of Visits: _____

Health Insurance: _____

Notes: _____



Registration

Date: _____ Sex: M ☐ F ☐ Age: _____ Birthdate: _____

Patient: _____ Social Security #: _____

Phone: _____ Home Phone: _____

Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Insured's Name: _____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Condition Related to: Illness ☐ Employment ☐ Auto ☐ Other ☐

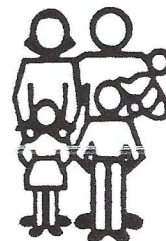
Employer	Company Name: _____ Occupation: _____ Phone: _____ _____ Street Address: _____ _____ City: _____ State: _____ Zip Code: _____
Spouse or Parent (Only if they carry the Health Insurance.)	Name: _____ Birthdate: _____ Social Security #: _____ _____ Company Name: _____ Occupation: _____ Phone: _____ _____ Street Address: _____ _____ City: _____ State: _____ Zip Code: _____
Patient Insurance Information	Mark any and all insurance coverage you and/or your spouse have applicable in this case: Medicare ☐ Blue Shield ☐ Auto Accident ☐

Medicaid [] Major Medical [] Union Plan [] Blue Cross [] Workers Compensation [] Other: _____ [] BCBS I.D. #: _____ Medicare/Medicaid I.D. #: _____ Major Medical or Auto Insurance: Date of Accident: _____ State: _____ Insurance Company: _____
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	Adjuster: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Claim #: _____ Policy #: _____ Effective Date: _____
Spouse Co-insurance Information	Major Medical Only Insurance Company: _____ Adjuster: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Policy #: _____ Claim #: _____ Effective Date: _____
Medical and Legal Information	Attorney: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Referred By: _____ Present Complaint: _____ Known Medical Problems: _____ Pregnant: Yes [] No [] Pacemaker: Yes [] No [] Family Physician: _____ Emergency Contact: _____ Phone: _____ Relation: _____

Patient Agreement	Assignment and Release: I, the undersigned, have insurance coverage with _____ and assign directly to _____ Doctor _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. Sign: _____ Date: _____ (Signature of Insured/Guardian)
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STEWART CHIROPRACTIC



Dr. Harold C. Stewart Jr.

P.O. Box 7603
5820 Veterans Parkway #308
Columbus, Georgia 31904

(706) 596-5200
(706) 596-5222 Fax
E-mail: stew121dc@aol.com

Private and Group Accident or Health Insurance
Assignment and Instructions for Direct Payment to Doctor

I hereby instruct and direct the _____ Insurance Company and/or my Attorney to pay by check, made payable to, and mailed directly to:

P.O. Box 7603 5820 Veterans Parkway #308 Columbus, Georgia 31904

If my current policy prohibits direct payment to the doctor, then I instruct and direct the insurance company to make the check payable to: Stewart Chiropractic and mailed to the above address in care of: Stewart Chiropractic, for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy; as payment towards the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee. Also, I agree to pay, in a current and timely

manner, any balance of said professional services charged over and above this insurance payment according to the financial policy of the above assignee.

**A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE
AND VALID AS THE ORIGINAL**

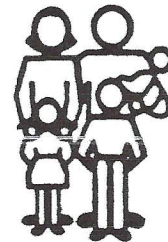
I also authorize the release of any information pertinent to my case to an insurance company, adjuster, or attorney involved in this case.

This authorization and assignment to the doctor listed above shall be irrevocable for the full extent of my treatment by said doctor and until such time that the medical expenses incurred have been paid in full.

Sign: _____ Date: _____
(Signature of Patient/Policyholder or Claimant of other than policyholder)

Witness: _____ Date: _____

**STEWART
CHIROPRACTIC**



Dr. Harold C. Stewart Jr.

P.O. Box 7603
5820 Veterans Parkway #308
Columbus, Georgia 31904

(706) 596-5200
(706) 596-5222 Fax
E-mail: stew121dc@aol.com

Dear _____,
(Patient Name)

We would like to take this time and welcome you to our office. Your treatments are very important and we ask that **if you need to cancel or reschedule an appointment please call at least an hour before the scheduled appointment time.**

If the doctor feels that you need time off from work due to your injuries, he will note it in the file and we will write you a work excuse. **If you stay out of work on your own and the doctor does not keep you out of work, he will not back-date any excuses.**

Being released from care means that we feel you are doing much better and we are finished with your treatment. **All reports, excuses, liens, itemized bill, etc. will be sent to your attorney or insurance company within seven business days of you being released.**

If you have any questions, please do not hesitate to contact our office.

Thank you,

Sign: _____ Date: _____
(Patient Signature)

Name: _____ Acct#: _____ Date: _____

1. Have you had similar problems or conditions before? Yes [] No []

If "yes" please give date(s) and explain: _____

2. Have you had any major illness in the past? Yes [] No []

If "yes" please give a date(s) and explain: _____

3. Have you had any injuries in the past? Yes [] No []

If "yes" please give date(s) and explain: _____

4. Have you had any accidents in the past? Yes [] No []

If "yes" please give a date(s) and explain: _____

5. Have you had any surgeries in the past? Yes [] No []

If "yes" please give a date(s) and explain: _____

6. Do you have or have you had any heart problems? Yes [] No []

If "yes" please give a date(s) and explain: _____

7. Do you have any implants? (pacemaker, arteries, IUD, breast, screws, metallic joints, plates, screens, etc.) Yes [] No []

If "yes" please give a date(s) and explain: _____

8. Have you ever had chiropractic care? Yes [] No []

Date of last treatment: _____

Name of Chiropractor last seen: _____

X _____

(Signature of Patient or Parent/Guardian if minor)

Accidental Injury Report MV

Name: _____ Today's Date: _____

Birthdate: _____ Date of Accident: _____

Traffic Accident

What kind of vehicle were you in during the accident? Truck [] Car [] SUV [] Van []

Location in vehicle: Driver [] Passenger []

Was your vehicle moving when the accident occurred? _____

Did another vehicle hit your vehicle(s)? _____

Did your vehicle hit another vehicle(s)? _____

Was impact from: Behind [] Right [] Left [] Front []

Describe accident and give location: _____

Were citations issued and to whom? Yes ☐ No ☐

Present Complaints

- ☐ Headaches
☐ Neck pain/stiffness
☐ Pain in shoulders (Right, Left or Both)
☐ Pins and needles in arms (Right, Left, or Both)
☐ Pins and needles in fingers (Right, Left or Both)
☐ Loss of grip in hands (Right, Left, or Both)
☐ Mid back pain
☐ Chest pain
☐ Lower back pain/stiffness
☐ Pain in hip (Right, Left, or Both)
☐ Pain down leg (Right, Left, or Both)
☐ Pain in knee (Right, Left, or Both)
☐ Pain in foot (Right, Left, or Both)
☐ Numbness in foot (Right, Left, or Both)

Name: _____ DoB: _____ Acct# _____

Present Symptoms

Cervical:

Location of Pain	Extension of Pain	Type of Pain	Severity of Pain	Pain Aggravated by
☐ Neck ☐ Right Arm ☐ Left Arm ☐ Bi-lateral ☐ Alternating	☐ Shoulder ☐ R ☐ L ☐ Scapular ☐ R ☐ L ☐ Upper Arm ☐ R ☐ L ☐ Forearm ☐ R ☐ L ☐ Wrist ☐ R ☐ L ☐ Hand ☐ R ☐ L ☐ Fingers ☐ R ☐ L	☐ Sharp (stabbing) ☐ Aching ☐ Throbbing ☐ Paresthesia ☐ Stiffness ☐ Soreness ☐ _____	☐ Minimal ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe	☐ Coughing ☐ Sneezing ☐ Staining ☐ Bowel Movement ☐ _____ ☐ _____ ☐ _____ ☐ Neck Flexion ☐ Neck Extension ☐ Neck Rotation ☐ Neck Lateral Flexion

Thoracic:

Location of Pain	Extension of Pain	Type of Pain	Severity of Pain	Pain Aggravated by
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☐ Mid-back ☐ Right Leg ☐ Left Leg ☐ Bi-lateral ☐ Alternating	☐ Right Int/Costal ☐ Left Int/Costal ☐ Back Muscle ☐ Bi-lateral	☐ Sharp (stabbing) ☐ Aching ☐ Throbbing ☐ Paresthesia ☐ Stiffness ☐ Soreness ☐ _____	☐ Minimal ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe	☐ Coughing ☐ Sneezing ☐ Staining ☐ Bowel Movement ☐ _____ ☐ _____ ☐ _____	☐ Neck Flexion ☐ Neck Extension ☐ Neck Rotation ☐ Neck Lateral Flexion
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Lumbar:

Location of Pain	Extension of Pain	Leg Pain	Type of Pain	Severity of Pain	Pain Aggravated by
☐ Back ☐ Right Leg ☐ Left Leg ☐ Bi-lateral ☐ Alternating	☐ Buttock ☐ R ☐ L ☐ Hip ☐ R ☐ L ☐ Thigh ☐ R ☐ L ☐ Knee ☐ R ☐ L ☐ Calf ☐ R ☐ L ☐ Ankle ☐ R ☐ L ☐ Foot ☐ R ☐ L ☐ Toes ☐ R ☐ L	☐ Before Back Pain ☐ After Back Pain ☐ As same as Back ☐ Unknown	☐ Sharp ☐ Aching ☐ Throbbing ☐ Paresthesia ☐ Stiffness ☐ Soreness ☐ _____	☐ Minimal ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe	☐ Coughing ☐ Flexion ☐ Sneezing ☐ Extension ☐ Staining ☐ Rotation ☐ Bowel Movement ☐ Lateral Flexion ☐ Standing ☐ Walking ☐ Laying Down

Head:

Headache	Other Head Symptoms		Insurance Company Definition of Pain
SA ☐ Entire Head SB ☐ Back of Head SC ☐ Forehead SD ☐ Temples SE ☐ Migraine	S6 ☐ Pain in Eyes S7 ☐ Light bothers eyes S8 ☐ Loss of Smell S9 ☐ Loss of Taste S10 ☐ Loss of Balance	S11 ☐ Dizziness S12 ☐ Loss of Hearing S13 ☐ Pain in Ears S14 ☐ Ringing in Ears S15 ☐ Buzzing in Ears	Minimal - Pain present but forgotten with activity Mild - Annoying but does not interfere with activity Moderate - Pain requires modification of activity but it is not disabling Severe - Patient is unable to perform normal duties due to pain Very Severe - Causes patient to cry out in pain

Onset of Pain: ☐ Gradual ☐ Sudden

Course: ☐ Progressively getting worse ☐ Getting Better ☐ Staying Same Other

Doctor(s) Seen:

☐ None ☐ Name: _____ Date: _____ ☐ X-Rays were taken

Results: ☐ None ☐ Improved ☐ Worse ☐ Same

Past History of Present Condition: ☐ Yes ☐ No If "yes" explain: _____

Pain Level Prior to Treatment: ☐ None ☐ (1 - 10) Level: _____ Area of Pain: _____

History of Present Condition:

☐ Alleges that on ____/____/____ while _____ how caused? _____
MM/DD/YYYY

☐ Alleges that condition is probably due to: _____

☐ Alleges that does not know exactly what caused condition but has been: _____

General Impression

Appears	Build	Gait	Minor(s)	Libman:	Vitals
☐ Stated Age ☐ Older ☐ Younger	☐ Slight ☐ Average ☐ Heavy	☐ Normal ☐ Protective of Injury ☐ Congenital Accommodation ☐ Neurologically Disturbed	☐ Antalgic ☐ Thigh ☐ Not Observed	☐ Normal ☐ Low ☐ High	Height: ____' ____ (or) ____ in Weight: _____ lbs Temp: _____ °F Blood Pressure: _____ / _____ Pulse: _____
Left ____/____		Right ____/____	Lying ____/____	Standing ____/____	