Dr. Patricia Cohen
5655 Lake Acworth Dr. Suite 230, Acworth, GA 30101
Ph: 770-966-8000 Fax: 770-966-1670

New Patient Registration and Accident Questionnaire

Name: ___________________________________ Age: _________Date of birth: ____________ Date: ___________
LAST FIRST MIDDLE

Address: _____________________________________Social Security #: ______________________ ☐ Male ☐ Female

City, State, Zip: ________________________________Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children__________

Home Phone (_____)____________________________Work Phone (_______) ________________________________

Cell Phone (_____) _____________________________Email address: _______________________________________

Employer: ___________________________________ Spouse's Name: ______________________________________

Occupation: _________________________________ Spouse's Employer: ____________________________________

In case of emergency, notify______________________ Relationship: ____________ Phone (_______) ___________

Current Symptoms: 1.__________________ 2.__________________ 3.__________________ 4.__________________

5. __________________ 6. __________________ 7. __________________ 8. __________________

When did your symptoms begin? ____

In general what makes your symptoms better? ____

In general what makes your symptoms worse? ____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): ________________________________

Are your symptoms local or do they travel to another area? (If they travel, to where?) ______________________________

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Where there any symptoms which you had after the crash that have now resolved? (please list)

____

Please list all medications and dosage: **Frequency** **For What Illness?**

____

____

List any allergies to medications, foods or other: ____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: ____

Do you smoke? ☐ Yes ☐ No; How much? ___________ Do you drink alcohol? ☐ Yes ☐ No; How much? ___________

Please list all serious illness and serious accidents: **Month and Year** **City, State**

____

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Patient's Name: ____ Date: _____________________

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

___

___

Date of Crash: _________________________________ Hour: _____________AM __________PM ________________

Specific Location of Crash: ____

Describe in detail, in your own words, how the crash/accident happened: __________________________________

___

___

AUTOMOBILE/MOTORCYLCE ONLY

In the crash: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? ____________________________________

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on ______________________________ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on __________________________________ (Street/Highway)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ *Dizziness*
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ Loss of Taste
☐ *Anxiety*	☐ Sensitivity to Light	☐ Jaw Pain	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms: ____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: ______________________ to _______________________

Where did you go after the crash? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _______________________

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** ____

Address: ____ Date of Hospitalization: ______________________

Attending E.R. Doctor: ____________________________________ Treatment Given? ______________________________

Have you done any of the following since the crash:

☐ Ice	☐ Medication (name)_______	☐ Rest
☐ Heat (any kind)	☐ Exercise	☐ Other________________

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Patient's Name: ____ Date: ____________________

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: ____

Address: _________________________________Telephone: (_____) _____________Insured: ________________

Claim #: ________________________________Policy #: __________________________________

Claim Representative: ________________________

Telephone: (______) ________________________ Fax: (_______) _________________________

Med-Pay Benefits: ____________ Uninsured (UM) Benefits: ___________ Underinsured (UIM) Benefits: __________

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: ____

Address: _________________________________ Insured: ____

Date of Birth: ___________________________Policy #: ________________________ SS#: ________________

Telephone: (______) ________________________ Fax: (_______) _________________________

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _________________________________

Address: ________________________________ Claims Rep: ____

Claim #: ________________________________Policy #: ______________________Insured: ________________

Telephone: (______) ________________________ Fax: (_______) _________________________

4) ATTORNEY: _____________________________________Legal Assistant: ____________________________

Address: ____

Telephone: (______) ________________________ Fax: (_______) _________________________

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: ________________________________ Date:___________________________________

Witness: ____Date: ___________________________________

Staff Initials: _______________

A Wellness Center by Dr. Patricia Cohen

PERSONAL HISTORY

Name____________________________________E-mail_______________________________________Date_________________

Address ____ City _______________________State _______ Zip ________________

Phone (H)______________________________(W)______________________________(Cell)______________________________

Birthdate_______________Age________Sex________Height__________Weight___________ Married Single Divorced Widowed Separated

Occupation____

Main complaint(s) that brought you to this office ____

List other doctors seen for this condition ____

When did this condition begin ____ Due to accident: Yes _______ No _______

List medication/vitamins now taking and why:

1. _______________________________________
2. _______________________________________
3. _______________________________________

List any injuries, operations, or pertinent history:

1. __________________________________Date_____________
2. __________________________________Date_____________
3. __________________________________Date_____________

Who referred you to our office: ________________________ N.Side News _____ Brightside ______ Phonebook ______ Insurance

Who is responsible for your bill besides yourself: (check one) ______ Insurance ______ Work Comp ______ Parents ______ Other

Name, address and phone of responsible party checked above: ____

____

_________________________________ Name of person on insurance policy _______________________________ Supervisor who authorized Workman's Comp.

Instructions: Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested. **Please check the symptoms you have experienced in either (or both) of the chronic (recurrent symptoms) or acute (symptoms you have now).**

Gastro-intestinal

Acute	Chronic	
_____	_____	Digestive complaints
_____	_____	Stomach pain
_____	_____	Ulcers
_____	_____	Frequent heartburn
_____	_____	Nausea
_____	_____	Frequent diarrhea
_____	_____	Irritable bowel
_____	_____	Hemorrhoids
_____	_____	Frequent vomiting
_____	_____	Colitis/diverticulitis
_____	_____	Black or bloody stool
_____	_____	Gallbladder trouble
_____	_____	Frequent burping/belching

Immune Response

Acute	Chronic	
_____	_____	Frequently sick
_____	_____	Frequent swollen glands/sore throats
_____	_____	Depression and/or anxiety
_____	_____	Achy joints/muscle pain
_____	_____	Headaches/migraines
_____	_____	Recurrent digestive complaints
_____	_____	Chronic fatigue
_____	_____	Food allergies
_____	_____	Eczema or hives
_____	_____	Allergies (mild / moderate / severe)

Structural/Neurological

Acute	Chronic	
_____	_____	Headaches
_____	_____	Muscle cramps/muscle spasms
_____	_____	Neck pain
_____	_____	Jaw pain
_____	_____	Dizziness
_____	_____	Back pain
_____	_____	Shoulder / elbow / wrist pain
_____	_____	Numbness/Tingling
_____	_____	Tremors in hands or feet
_____	_____	Knee pain / Hip pain
_____	_____	Joint pain or loss of function
_____	_____	Osteoporosis/Osteomalacia
_____	_____	Current bone fracture or injury
_____	_____	Tendonitis/Bursitis

Cardiovascular

Acute	Chronic	
_____	_____	Irregular heartbeat
_____	_____	Heart murmur/palpitations
_____	_____	High or low blood pressure
_____	_____	Chest pain
_____	_____	Previous heart trouble
_____	_____	Poor circulation
_____	_____	Previous heart surgery
_____	_____	Varicose or spider veins
_____	_____	Hands and feet cold all the time

Name: **A Wellness Center by Dr. Patricia Cohen**

Respiratory

Acute	Chronic	
_____	_____	Chronic cough
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Recurrent head colds
_____	_____	Recurrent sinus infections
_____	_____	Recurrent bronchitis
_____	_____	Smoker

Genito-Urinary

Acute	Chronic	
_____	_____	Too frequent urination
_____	_____	Discolored or foul-smelling urine
_____	_____	Blood in urine
_____	_____	Recurrent kidney or bladder infections
_____	_____	Kidney stones
_____	_____	Bedwetting
_____	_____	Inability to control bladder

Eyes/Ears

Acute	Chronic	
_____	_____	Recurrent ear infections
_____	_____	Eye infections
_____	_____	Slowly losing vision
_____	_____	Floaters in eyes
_____	_____	Glaucoma
_____	_____	Macular degeneration
_____	_____	Cataracts
_____	_____	Diabetic retinopathy

Miscellaneous

Past	Present	
_____	_____	Difficulty sleeping
_____	_____	Restless, uneasy sleep
_____	_____	Edema
_____	_____	Unusual swelling in arms or legs
_____	_____	Tobacco _____packs/day
_____	_____	Alcohol _____ drinks/day / week / month
_____	_____	Drug or Alcohol Dependence
_____	_____	Coffee/Tea/Caffeinated Soft drinks: cups/cans per day _____________

Have you or your family had:

Self	Family	
_____	_____	Cancer
_____	_____	Epilepsy
_____	_____	Chronic Back Problems
_____	_____	Chronic Headaches
_____	_____	High Blood Pressure

Endocrine (Glandular)

Acute	Chronic	
_____	_____	Cold hands and feet
_____	_____	Low blood pressure
_____	_____	Weight problems (over or under)
_____	_____	Thyroid problems
_____	_____	Diabetes
_____	_____	Irritable if meals are missed
_____	_____	Anxiety/nervousness/irritability
_____	_____	Dizzy upon standing too quickly
_____	_____	Weak and shaky
_____	_____	Hyperactive behavior
_____	_____	Depression
_____	_____	Very susceptible to infections
_____	_____	Frequent headaches
_____	_____	Digestive complaints

For Women Only

Acute	Chronic	
_____	_____	Recurrent urinary tract infections
_____	_____	Yeast infections
_____	_____	Vaginal discharge
_____	_____	Menstrual irregularity
_____	_____	Cramping
_____	_____	Mood swings/depression
_____	_____	Pre-menstrual syndrome
_____	_____	Infertility
_____	_____	Frequent miscarriages
_____	_____	Hot flashes
_____	_____	Currently taking hormone medication
_____	_____	Currently taking birth control pills
_____	_____	Lumps in breast
_____	_____	Uterine cysts/ovarian cysts
_____	_____	Bladder leaks too easily
_____	_____	Endometriosis
		Pregnancy, # of Births ______
Y	N	Birth Control Pills, Type ____________________

For Men Only

Acute	Chronic	
_____	_____	Prostate trouble
_____	_____	Urination problems
_____	_____	Reproductive problems

Self	Family	
_____	_____	Rheumatoid Arthritis
_____	_____	Diabetes
_____	_____	Heart Problems
_____	_____	Lung Problems
_____	_____	Lupus

Please read below and sign. Thank You!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Cohen's office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to Dr. Cohen will be credited to my account on receipt. I further authorize Dr. Cohen to accept assignment of insurance benefits. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. A 1% monthly service charge will be applied to any balance that extends beyond 90 days.

Patient's Signature ____ Date ___________________

Guardian or Spouse's
Signature Authorizing Care ____ Date ____________________

A Wellness Center by Dr. Patricia Cohen

OFFICE POLICY REGARDING
MOTOR VEHICLE ACCIDENTS

We will bill the Med Pay on your automobile insurance policy. Not all individuals purchase Med Pay on their auto policy so bring in your declaration page for us to verify or call your agent to verify over the phone. We will bill Med Pay first REGARDLESS of who was “at fault”. By law, using your med pay cannot make your premiums go up.

If Med Pay is not available, as a courtesy to you, we will hold a lien for your accrued billing with your attorney to be paid in full at the time of settlement.

If for any reason Med Pay or “at fault” insurance is not available to you and, “IF” your policy covers chiropractic, we will submit all of your claims to your Major Medical Health Insurance. Keep in mind that your coverage will be limited to the provisions of your policy. For example: If you have a $500 deductible, $35 co-pay and 20 visits per year then this is how your visits will be processed through our office. You will also be asked by your insurance of proof that no other payment on your accident has been made, otherwise you will be responsible to reimburse them.

If you are the victim of a “hit and run” or the “at fault” party is an uninsured motorist, we will submit our billing directly to your automobile insurance carrier to be paid by your uninsured motorist provision.

Please note if all payment options above have been exhausted and payment has not been rendered to our office, you will be responsible for your balance in full. Payment plans can be arranged with our billing manager. We accept Visa, MC, Discover cards and personal checks.

1.5% interest per month will begin to accrue on any outstanding balance 120 days after release from care.

If you have any questions please feel free to ask, and we will be glad to help you.

Patient Signature: ____

Date: ____

Lien Notice

I, the undersigned patient, am directing my insurance company, ____________________ to pay in full any and all outstanding bills owed to Dr. Patricia Cohen, out of my medical payments coverage. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his/her awaiting payment.

Signed ____ Date__________________

Witness _______________________________________ Date__________________

ATTORNEY REPRESENTATION and PROTECTION of BALANCE

I, the undersigned patient, am directing my Attorney, ____________________________ to pay in full any and all outstanding bills owed to Dr. Patricia Cohen, out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Signed ____ Date ________________

Witness ____ Date ________________