CONFIDENTIAL PATIENT INFORMATION

The following information is needed to better serve you. Please complete all questions. If you need help, please ask the front desk assistant. PLEASE PRINT.

PATIENT: Today's Date ____/____/____

Last Name:_____ First Name_____ Middle Initial: ____

Gender: M F Date of Birth: ___/___/___ Age: ____ Marital Status: S M W D No of children:_____

Home Address: _____City:_____ State: ____ Zip: _____

Home phone: _____Cell phone:_____ Email:_____

Employer: _____ Occupation: _____ Years of employment ____

Employer Address: _____City: _____ State: ____ Zip: _____

Work phone: _____ SS#: _____ Driv Lic #:_____

SPOUSE or GUARDIAN or RESPONSIBLE PARTY:

Last Name:_____ First Name_____

Date of Birth: ___/___/___ SS#: _____ Relation to patient: _____

Employer: _____ Occupation: _____ Work phone: _____

PAYMENT Circle one method of payment: Cash Check Visa MasterCard

INSURANCE INFORMATION:

Insurance Company:_____ Insured's Name: _____

ID/Policy #_____ Insured Date of Birth: ___/___/___

Plan Name: _____ Group #_____

Describe the major complaint(s) that bring you to the our office: _____

_____

Is your condition due to an accident? Yes ___ No ___ If yes, Date of Accident: _____/_____/_____

Type of Accident? Auto___ Work/On job ____ At Home ____ Sports ____ 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 and non covered. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable.
I, the undersigned, hereby authorize Dr. Sautré to perform necessary examination, diagnostic tests, including but not limited to radiographs, and to administer chiropractic care as necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Signature _____ Date: _____/_____/_____

(Patient, Parent, Legal Guardian or Responsible Party)

PATIENT NAME _____ DATE _____

Your body is designed to function at its maximum potential. Throughout life, events occur which may damage your health expression. This questionnaire will uncover the layers of damages, especially to your spine and nervous system that have affected your quality of life and health.

HEALTH INFORMATION Please Circle

Do you have back pain? Describe _____ Yes No
Do you have neck pain? Describe _____ _____ Yes No
Do you experience pain in other articulations? Describe _____ Yes No
Do you like your posture? _____ Yes No
Do you practice spinal stretching on a routine basis? _____ Yes No
Do you feel some restriction with certain movements? Describe _____ Yes No
Do you think you have spinal degeneration? _____ Yes No
Have you ever had a serious injury to your head, neck or spine? _____ Yes No

FROM BIRTH TO ADULTHOOD

Was your birth process difficult?	Yes	No	Were you breastfed?	Yes	No
Did you carry a heavy backpack?	Yes	No	Did you experience serious falls?	Yes	No
Did you have ear infections?	Yes	No	Where you picked on by siblings?	Yes	No
Did you eat healthy food?	Yes	No	Where you pulled by your arm?	Yes	No
Did you have teeth problems?	Yes	No	Were you taught how to take care of your spine?	Yes	No

Did you experience mental stress at school or with family? Yes No
Have you been in accidents or sports injuries or trauma? Yes No

Please indicate if you had (or been diagnosed with) any of the following:

Alcoholism	Yes	No	Fracture	Yes	No	Pacemaker	Yes	No
Allergies	Yes	No	Goiter	Yes	No	Parkinson's	Yes	No
Anemia	Yes	No	Gout	Yes	No	Pinched nerve	Yes	No
Appendicitis	Yes	No	Heart Trouble	Yes	No	Prostate problems	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No	Psychiatric care	Yes	No
AIDS	Yes	No	Hernia	Yes	No	Respiratory conditions	Yes	No
Blood disease	Yes	No	Herniated disc	Yes	No	Stroke	Yes	No
Breast Lumps	Yes	No	High Cholesterol	Yes	No	Suicide attempt	Yes	No
Bulimia	Yes	No	Kidney Condition	Yes	No	Thyroid problems	Yes	No
Cancer	Yes	No	Liver Condition	Yes	No	Tumors/Growths	Yes	No
Chest pain	Yes	No	Headaches	Yes	No	Ulcers	Yes	No
Low blood pressure	Yes	No	Hypertension	Yes	No	Skin problems	Yes	No
Diabetes	Yes	No	Miscarriages	Yes	No	Indigestions	Yes	No
Epilepsy	Yes	No	Multiple Sclerosis	Yes	No	Swelling in legs/ankles	Yes	No
Earring problems	Yes	No	Muscle Spasms	Yes	No	Skin conditions	Yes	No
Eye condition	Yes	No	Osteoporosis	Yes	No	Sinus pain	Yes	No
Genital condition	Yes	No	Loss of balance	Yes	No	Urinary problems	Yes	No
Fertility issues	Yes	No	Ringing in ears	Yes	No	OTHER _____		

Are you taking any medications, birth control pills, or drugs? What? _____ Yes No

Please Circle All That Apply:

EXERCISE	**WORK ACTIVITY**	**NUTRITION**	**REST**
None	Sitting/Standing	8-10 glasses of water daily	Sleeping on the back / Side
Moderate	Light labor	Fresh fruits and vegetable	Sleeping on the stomach
Daily	Heavy labor	Skip meals	I have a day off each week
Training Program	Stress: Moderate - Severe	Caffeine - Alcohol	After sleeping, I feel Good - Tired

SOCIAL AND PERSONAL HISTORY		**FAMILY HISTORY**	
Smoking	Family Stress: Mild-Moderate - Severe	Scoliosis	Cardiovascular condition
Enjoy sufficient recreation time	Pray or meditate	Cancer	Diabetes
Spend time with family or friends	Feel depressed	Stroke	Other:_____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status, I shall inform the doctor and staff at the next appointment.

X_____ **DATE** _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Serge Sautre, D.C., PC.
Dr. Serge Sautré, Chiropractor
3288 Chamblee Tucker Rd, Atlanta, GA 30341
Phone 770-451-0799, Fax 770-451-0815

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Serge Sautré to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dr. Sautré's Notice of Privacy Practices provides a more complete description of such uses and disclosures and is available for review.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Serge Sautré reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Serge Sautré, D.C., PC, 3288 Chamblee Tucker Rd, Atlanta, GA 30341.

With this consent, Dr. Serge Sautré and/or his designated representatives may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Sautré and/or his designated representatives may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Confidential.

With this consent, Dr. Sautré and/or his designated representatives may email to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Serge Sautré and/or his designated representative restrict how he/she uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Serge Sautré and/or his designated representatives use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Serge Sautré and/or his designated representatives may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian