Haberski Wellness Center
798 Rays Rd., Suite 103
Stone Mountain, GA 30083
404-294-5050

_____
(Case No.)

NEW PATIENT INFORMATION

(PLEASE PRINT)

HOME PHONE _____
CELL PHONE _____

Name _____ Email_____

Address _____ City _____ State _____ ZIP _____

Age _____ Birthdate ___ / ___ / _____ Sex _____ Marital Status _____No. of Children _____

Occupation _____ Social Security # _____ - _____ - _____

Employed By _____ Address _____

Work Phone _____ Referred By _____

Have you ever had chiropractic care before? ( ) YES ( ) NO
If yes, where and when: _____

Please list your chief complaints in order of severity . . . .

1) _____ For how long _____

2) _____ For how long _____

3) _____ For how long _____
Caused By: Fall _____ Strain _____ Accident _____ Gradually Onset _____

List other doctors consulted for these conditions . . . . .

1) _____ Address _____
Treatment: _____ Results _____

2) _____ Address _____
Treatment: _____ Results _____

Are you on any medications now? ( ) Yes ( ) No List: _____
_____

Do you take any over the counter pharmaceuticals? ( ) Yes ( ) No List: _____

Do you take vitamins or herbs? ( ) Yes ( ) No List: _____
_____

Type and amount of exercise: _____

Any previous serious disorders or health problems? _____
_____

Please list any operations you had: _____
_____
_____

Have you ever broken or fractured any bones? _____

Family health history? ( ) Cancer ( ) High Blood Pressure ( ) Heart Disease ( ) Stroke ( ) Diabetes ( ) Asthma
( ) Autoimmune ( ) Neurological conditions _____

Do you have health insurance? ( ) YES ( ) NO

Policy NO. _____ Group NO. _____

Company Name: _____ Phone _____

Address to mail claims: _____

Medicare Coverage? ( ) YES ( ) NO
Policy NO. _____

Medicaid Coverage? ( ) YES ( ) NO
Policy NO. _____

Are you covered under any other group or individual healthcare policy through yourself or your spouse?
( ) YES ( ) NO

Company Name _____

Address _____

Policy NO. _____ Group NO. _____

Spouse's Name _____ Social Security # _____ - _____ - _____

Occupation: _____ Employer _____

Address _____

Work Phone _____ Birthdate _____ / _____ / _____

In case of emergency, Notify _____

Address _____

Phone _____

I herby authorize the Doctor to treat my condition as he deems appropriate through the use of chiropractic adjustments and/or other therapies which might include: kinesiology, massage, physiotherapy, B.E.S.T., TBM, laser therapy, LED light therapy, foot bath detox, Dr. Brimhall Health Scan, reflexology, homeopathies, nutritional counseling, herbs, aromatherapy, supplementation, therapeutic non-touch, chemical and/or metal detoxification, and diet, throughout my body. This office does not diagnose or claim to treat any medical condition or disease, nor prescribe any remedies, herbs, homeopathies, or supplements for a previously diagnosed medical disease. Any medical concerns or treatment should always be discussed with your medical doctor. It is understood and agreed the amount paid for X-rays, if needed, is for examination only and the X-ray negatives will remain the property of this office where they may be seen at any time while a patient of this office.

I have read the above explanation of the adjustment and other related services. I have discussed this with the doctor during the examination and all reasonable effort was made to screen for any contraindications to my care. I have informed the doctor of all of my conditions that would otherwise not come to his attention, and it is my responsibility to inform him of everything. All of my questions have been answered to my satisfaction. By signing below, I understand all aspects of the above statements and hereby give my consent to receive recommended services.

_____ _____
(Date) (Patient Signature)

Guardian or Spouse's
Signature Authorizing Care _____ Date _____ / _____ / _____